Heath
Family Dentistry

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WELCOME

Today's date:

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Preferred Name:	Social Security#:	Birth Date: / /	Age:	Sex: ❑ M ❑ F	
Street Address:		Home #: ( )		Cell #: ( )	
P.O. box:	City:		State:	ZIP Code:	
Occupation:	Employer:			Employer Phone #: ( )	

Referred By Who:

❑ Family ❑ Friend ❑ Brochure by Mail ❑ Insurance Co ❑ Online

Other family members seen here:

INSURANCE INFORMATION

Insurance:	Subscriber's Name:		
Birth Date: / /	Group#:	Subscriber ID:	

Relationship to Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of Secondary Insurance (if applicable):	Subscriber's Name:	Birth Date: / /	Group#:
ID#:			

Patient's Relationship to Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of Friend or Relative (not living at same address):	Relationship to Patient:	Home/Cell #: ( )

Have you been told that you snore or hold your breath while sleeping or wake up gasping for air? Yes or No

Have you ever been given a CPAP device? Yes or No

If you have been given any form of CPAP, do you use it nightly? Yes or No

Are you comfortable with your CPAP and satisfied with its use? Yes or No

MEDICAL HISTORY

It is important that we are aware of your health history. Please complete this section thoroughly and check Yes or No, Circle and explain where appropriate.

Artificial Joints	___Yes ___No	Artificial Valves	___Yes ___No	Arthritis	___Yes ___No
Brain Injury	___Yes ___No	Diabetes	___Yes ___No	Fainting/Seizures/Epilepsy	___Yes ___No
Organ Transplant	___Yes ___No	Kidney/Liver Disease	___Yes ___No	Stroke	___Yes ___No
Heart Disorder Attack/Surgery/Pace Maker/Stents	___Yes ___No	Herpes/Fever Blisters	___Yes ___No	HIV/AIDS	___Yes ___No
Anemia/Bleeding Disorder	___Yes ___No	Hepatitis A/B/C	___Yes ___No	Tuberculosis	___Yes ___No
Ulcers	___Yes ___No	Colitis	___Yes ___No	High/Low Blood Pressure	___Yes ___No
Lung Problems/Asthma Chronic Obstructive Pulmonary Disease	___Yes ___No	Cancer/ Radiation Treatment/Chemotherapy	___Yes ___No	History of Infective Endocarditis	___Yes ___No
Hearing/Speech Disorder	___Yes ___No	Drug/Alcohol Abuse	___Yes ___No	Psychiatric Treatment	___Yes ___No
Eating Disorder	___Yes ___No	Sinus Problems	___Yes ___No	Surgery	___Yes ___No
Thyroid Disorder	___Yes ___No	Headaches/Migraines	___Yes ___No	High Cholesterol	___Yes ___No

If you answered Yes to any of the above please explain:

_____

_____

List any drugs or medications presently taking (doses/times per day)

_____

_____

List any **allergies to drugs or medication**

_____

Do you have a **LATEX Allergy?** ___Yes ___No Are you Pregnant or Nursing? ___Yes ___No Do you Smoke? ___Yes ___No

Are you currently under the care of a physician? ___Yes ___No Please Explain_____

Physician's Name & Phone #_____

Previous Dentist Name_____ Last Dental Visit_____

Are you currently in pain? ___Yes ___No Have you had a problem with any prior dental treatment? ___Yes ___No

Have you experienced pain with your jaw (TMJ or TMD) ___Yes ___No

I understand that the information given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in health status and/or use of medications and any applicable personal and/or insurance information. I hereby authorize the dental staff to perform any necessary diagnosis and treatment needed for proper dental care.

I also authorize this practice to forward any dental records that may be necessary to complete the processing of a claim by all insurance companies. I further authorize reimbursement directly to this practice from all insurance companies.

_____ _____

Signature Date

Updated_____ _____ _____

_____ _____ _____