HEALTH HISTORY

Mr. Mrs. Miss. Ms_____ Birthdate_____

Local Address_____City _____Zip _____

Phone _____ Cell Phone_____ Email Address_____

Are you a Permanent resident or Seasonal?_____ Method of payment, cash___check_____credit card

Occupation _____ Employer _____ Phone No._____

Dental Insurance _____Group or Plan No. _____ ID #_____

Spouse Name _____ Birthdate _____Employer_____

Person to Contact in case of Emergency – Name _____ Phone No._____

1. What is the reason for today's visit?_____Referred by?_____
2. If there was a simple inexpensive way to whiten your teeth, would you interested?_____
3. What did you like most about your last dental office? _____

Physician_____ Phone No._____Date of Last Physical _____

Have you had any recent Surgery? _____

Do you have any Drug Allergies or an adverse reaction to any medication?____if so what_____

Do you have a LATEX ALLERGY?_____

Have you ever been told to Premedicate prior to any dental appointment?_____

Are you taking any medication at this time? _____ If so,what? _____

Are you taking any BONE STRENGTHENING MEDICATION such as Fosamax, Actinol, Boniva etc
If so for how long?_____

Are you on any type of BLOOD THINNER? _____

Are you under the care of a physician? _____, If so, for what condition _____

Do you suspect that you are Pregnant? _____ Are you Nursing _____

IF YOU HAVE EVER HAD ANY OF THE FOLLOWING, <u>CIRCLE</u> THOSE THAT APPLY

Heart Murmur
Heart Disease_____
i.e. stroke, bypass, valve replacement
Low Blood Pressure
High Blood Pressure
Mitral Valve Prolapse
Cancer___
Radiation Treatment
Artificial Joints _____
Recent Weight Loss
Back problems
Diabetes
Epilepsy
Headaches
Hepatitis, Jaundice, or Liver Disease
Nervous Problems
Psychiatric Care
Chemical Dependency
Allergy to Anesthetics
Swollen Neck Glands
General Allergies
Blood Disease
Arthritis
Special Diet
Rheumatic Fever
Sinus Problems
AIDS/HIV
Thyroid Disease
Circulatory Problems
Ulcer
Venereal Disease
Hemophilia
Temporomandibular joint (TMJ)
Respiratory Disease
Other_____

I agree to assume full Financial Responsibility for all treatment rendered irrespective of insurance payments or fee schedules.

Date _____ Signature _____