

HEALTH HISTORY

These questions are for your benefit. They assure that any dental treatment will take into consideration your past and present health status. Please fill out each question completely; they are for our records only and are confidential.

PATIENT

Name: _____ Birth Date: _____ Marital Status: _____
Home Address: _____ City: _____ Zip Code: _____
Home Phone: _____
Driver's License #: _____ Social Security #: _____
Employed by: _____ Address: _____ How long? _____
Occupation: _____ Business Phone: _____

SPOUSE

Name: _____ Birth Date: _____ Social Security #: _____
Employed by: _____ Address: _____ How long? _____
Occupation: _____ Business Phone: _____

INSURANCE

Yes No Do you have dental insurance? Is insurance via: Self Spouse or Both Employments
Primary Insurance Carrier's Name: _____ Group/Policy #: _____
Address: _____
Secondary Insurance Carrier's Name: _____ Group/Policy #: _____
Address: _____

OTHER

Name of Dentist: _____ Address: _____ How long? _____
Name of Physician: _____ Address: _____ How long? _____
Whom should we thank for referring you? _____
In case of emergency, whom should we contact? _____ Phone: _____

MEDICAL HISTORY

1. Yes No Are you in good health? If no, what is the nature of your illness? _____

2. Yes No Are you now under the care of a physician? If yes, for what purpose? _____

3. Yes No Have you ever been hospitalized or had any serious illness or operation? If yes, explain: _____

4. Yes No Do you have a pacemaker or artificial heart valve, artificial joints or other artificial devices?
If yes, explain: _____

5. Yes No Have you had radiation treatment or chemotherapy drugs? If yes, explain: _____

6. Yes No Have you had massive bleeding requiring special treatment? If yes, explain: _____

7. Please list any medication you are currently taking, their purpose and their dosage: _____

(OVER PLEASE)