We are happy to have you join our great family of patients and friends. The benefits of a healthy, beautiful smile are never-ending, and our goal is to provide a safe and comfortable environment while providing you the highest quality of care. Please complete this form to the best of your ability so we can provide the best possible care.

Health History Form

PATIENT NAME:_____DATE: _____

BIRTHDATE: _____ AGE: _____ SOCIAL SECURITY # : _____

MALE: _____ FEMALE: _____ SINGLE: _____ MARRIED: _____ WIDOW: _____

ADDRESS:

_____
STREET APARTMENT #

_____
CITY STATE ZIP CODE

TELEPHONE:
(HOME) : _____ (WORK): _____ (CELL) : _____

EMAIL: _____

HEALTH INFORMATION

1. Do you premedicate before a dental visit? Yes No
   If yes, for what reason: _____

   What do you premedicate with? _____

   Do you take anticoagulants (blood thinners) such as (Please circle):

   - Clopidogrel (Plavix)
   - Dipyridamole (Persantine)
   - Prasugrel (Effient)
   - Ticagrelor (Brilinta)
   - Vorapaxar (Zontivity)
   - Xarelto (Rivaroxabn)
   - Warfarin

• Aspirin

2. Are you allergic to any medications? Yes No
   If yes, please list: _____

3. Are you currently taking any medications? Yes No
   If yes, please list: _____

4. Are you currently under the care of a physician? Yes No
   If yes, please explain: _____

5. Do you use any tobacco products? Yes No
   If yes, please explain: _____

6. Have you ever had any complications from dental treatment? Yes No
   If yes, please explain: _____

7. Do your gums bleed: Yes No

8. Have you been told you have gum disease? Yes No

9. Have you been told you have bad breath? Yes No

10. Have you ever had any pain in your jaw joints? (clicking/popping) Yes No

11. Are you happy with your smile? Yes No
    If no, please explain: _____

12. FEMALE PATIENTS: Are you pregnant? Yes No
    If yes, expected due date is : _____

13. Circle Yes or No to the following:

AIDS	Y	N	High Blood Pressure	Y	N
Diabetes	Y	N	Hepatitis A, B or C	Y	N
Epilepsy	Y	N	Arthritis	Y	N
Rheumatic Fever	Y	N	Prolonged Bleeding	Y	N
Heart Disease	Y	N	Cancer	Y	N
Mitral Valve Prolapse	Y	N	Asthma	Y	N
Heart Attack	Y	N	Fainting Spells	Y	N
Liver or Kidney Disease	Y	N	Tuberculosis	Y	N
Heart Murmur	Y	N	Anemia	Y	N
Stroke Y	N		Stomach Ulcers	Y	N
Organ Transplant	Y	N	Thyroid Problems	Y	N
Chest Pain/Angina	Y	N	Latex Allergy/Reaction	Y	N
Sleep Apnea	Y	N	Artificial Heart Valve	Y	N

Chemotherapy	Y	N	Hemophilia	Y	N
Convulsions	Y	N	Psychiatric Care	Y	N
Pacemaker	Y	N			

Reason for this Visit : _____
Date of last dental visit: _____
Date of last xrays: _____

To the best of my knowledge, all the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

My signature authorizes treatment. _____
Signature of patient, parent or guardian

Date : _____

REFERRAL INFORMATION

Whom may we thank for referring you to our practice?

- o Another patient, friend or relative
  If so, Who: _____
- o Dental Office
- o School Social
- o Media
- o Other _____

Name of the office referring you to our practice:

_____

DENTAL INSURANCE INFORMATION

Primary Name of insured: _____
Is the insured a patient? Yes No

Insured's Birth Date: _____

Subscriber's Social Sec. # : _____

Subscriber ID #: _____

Subscriber Group #: _____

Subscriber Address:

_____
Street City State Zip Code

Subscriber's Employer Name: _____

Patients relationship to insured:
Self Spouse Child Other: _____

DENTAL INS. CO.: _____

DENTAL INSURANCE: ADDRESS:

_____
Street Suite #

_____
City State Zip Code

DENTAL CLAIMS PHONE #: _____
DENTAL CLAIMS FAX # : _____ (IF AVAILABLE)