

HEALTH HISTORY FORM

NAME _____ SINGLE MARRIED PARTNERED WIDOWED DIVORCED
AGE _____ BIRTHDATE _____ S.S.NO. _____ EMAIL ADDRESS _____
RESIDENCE ADDRESS _____ HOME PHONE _____
CELL PHONE _____
EMPLOYED BY _____ BUS. PHONE _____
PRESENT POSITION _____
NAME OF SPOUSE _____ SPOUSE EMPLOYER _____
REFERRED BY _____
PERSON RESPONSIBLE FOR THIS ACCOUNT _____
DENTAL INSURANCE PLAN (IF ANY) _____
INSUR. CO. GROUP NO. EMPLOYER NAME INSURED'S NAME INSURED SS#

IT IS IMPORTANT THAT I KNOW ABOUT YOUR DENTAL AND MEDICAL HISTORY, MANY THINGS HAVE A DIRECT BEARING ON YOUR DENTAL TREATMENT. INFORMATION YOU PROVIDE IS STRICTLY CONFIDENTIAL.

YOUR MEDICAL HISTORY

PHYSICIAN'S NAME _____ PHONE NO. _____
DATE OF LAST VISIT _____ FOR WHAT PURPOSE? _____
HAVE YOU EVER HAD A SERIOUS ILLNESS OR BEEN HOSPITALIZED? YES NO
IF SO, EXPLAIN _____
CURRENT BLOOD PRESSURE _____ / _____
DO YOU PREMEDICATE WITH AN ANTIBIOTIC PRIOR TO DENTAL WORK? YES NO
INDICATE WITH A CHECK MARK ANY OF THE FOLLOWING WHICH APPLY TO YOUR PAST OR PRESENT HEALTH

- | | |
|---|--|
| _____ ALLERGIES TO LOCAL ANESTHETICS | _____ EPILEPSY, SEIZURES |
| _____ ALLERGIES TO MEDICINE OR DRUGS | _____ BLOOD TRANSFUSIONS |
| _____ OTHER ALLERGIES _____ | _____ HEPATITIS A B C (CIRCLE) |
| _____ HEART ATTACK (M.I.) | _____ CANCER |
| _____ HEART CONDITION _____ | _____ CHEMOTHERAPY |
| _____ HEART MURMUR | _____ RADIATION THERAPY |
| _____ HIGH BLOOD PRESSURE | _____ TRANSPLANTS |
| _____ LOW BLOOD PRESSURE | _____ ARTHRITIS, RHEUMATISM |
| _____ CARDIAC PACEMAKER | _____ STEROIDS (CORTISONE) |
| _____ ARTIFICIAL HEART VALVE | _____ BIPHOSPHONATE (FOSAMAX, ACTONEL, BONIVA) |
| _____ SHORTNESS OF BREATH | _____ DIABETES |
| _____ BRUISE EASILY | _____ GLAUCOMA |
| _____ SWELLING OF ANKLE | _____ ASTHMA |
| _____ STROKE | _____ LUNG DISEASE (i.e. EMPHYSEMA) |
| _____ RHEUMATIC FEVER | _____ TUBERCULOSIS |
| _____ ANEMIA | _____ STOMACH ULCERS |
| _____ BLEED EXCESSIVELY | _____ PSYCHIATRIC/PSYCHOLOGICAL CARE |
| _____ BLOOD THINNER (COUMADIN, ASPIRIN, PLAVIX, TICLID) | _____ SINUS PROBLEMS |
| _____ FAINTING OR DIZZINESS | _____ COLD SORES |
| _____ MIGRAINE HEADACHES | _____ HERPES |
| _____ ARTIFICIAL JOINT (HIP, KNEE, etc.) | _____ VENEREAL DISEASE |
| | _____ AIDS/HIV POSITIVE |

IF FEMALE, ARE YOU CURRENTLY PREGNANT? YES NO
DO YOU HAVE ANY DISEASE, CONDITION, OR PROBLEMS NOT LISTED ABOVE? _____
MEDICATIONS PRESENTLY BEING TAKEN: _____

(OVER)

YOUR DENTAL HISTORY

1. WHAT IS THE REASON FOR YOUR VISIT? _____
2. DATE OF LAST DENTAL VISIT? _____ WHAT WAS DONE AT THAT VISIT? _____
3. DATE OF LAST CLEANING? _____ HOW OFTEN DO YOU HAVE CLEANINGS? _____

YES

NO

- ____ ARE YOU HAVING ANY DISCOMFORT AT THIS TIME? WHERE? _____
- ____ DO YOU HAVE ANY SENSITIVE TEETH? (HOT, COLD, SWEETS)? WHERE? _____
- ____ DO YOU HAVE DISCOMFORT WHEN BITING OR CHEWING? WHERE? _____
- ____ DO YOU HAVE SWELLING OR A LUMP IN YOUR MOUTH? WHERE? _____
- ____ DO YOU HAVE ANY UNPLEASANT TASTES IN YOUR MOUTH?
- ____ DO YOU HAVE ANY CONCERNS ABOUT HAVING BAD BREATH (HALITOSIS)?
- ____ DOES FOOD WEDGE BETWEEN YOUR TEETH? WHERE? _____
- ____ ARE YOU SATISFIED WITH THE APPEARANCE OF YOUR TEETH? (COLOR, SHAPE, OVERALL SMILE)
- ____ HAVE YOU EVER HAD PERIODONTAL (GUM) TREATMENT? BY WHOM? _____
- ____ HAVE YOU EVER HAD ORTHODONTIC (BRACES) TREATMENT? BY WHOM? _____
- ____ HAVE YOU EVER HAD ENDODONTIC (ROOT CANAL) TREATMENT? BY WHOM? _____
- ____ HAVE YOU EVER HAD ORAL SURGERY OR IMPLANTS PLACED? BY WHOM? _____
- ____ HAVE YOU HAD A FULL MOUTH SERIES OF X-RAYS (18) TAKEN WITHIN THE PAST YEAR?
- ____ DO YOU HAVE PAIN IN OR NEAR YOUR EARS, POPPING, CLICKING NOISES WHEN CHEWING?
- ____ IS THERE PAIN ON OPENING WIDE OR MOVING YOUR JAW FROM LEFT TO RIGHT?
- ____ ARE YOU AWARE IF YOU GRIND OR CLENCH YOUR TEETH?
- ____ HAVE YOU EVER HAD AN INJURY OR TRAUMA TO YOUR FACE OR JAW?
- ____ DO YOU SMOKE OR CHEW TOBACCO?
- ____ DO YOU USE DENTAL FLOSS? HOW OFTEN? _____
- ____ WHAT TYPE OF TOOTHBRUSH DO YOU USE? SOFT BRISTLE ELECTRIC

NOTICE OF PRIVACY PRACTICES:

I HAVE BEEN INFORMED OF AND BEEN GIVEN THE RIGHT TO REVIEW AND SECURE A COPY OF YOUR NOTICE OF PRIVACY PRACTICES.

VISUAL IMAGES: I GIVE DR. SUPOWITZ PERMISSION FOR VISUAL IMAGES OF MY SMILE (TEETH AND LIPS ONLY, NOT FULL FACE) MADE IN CONNECTION WITH MY DENTAL EXAMINATION AND/OR TREATMENT FOR EDUCATIONAL PURPOSES PRIMARILY IN HIS OFFICE, BUT MAY BE UTILIZED FOR EDUCATIONAL PRESENTATIONS TO DENTISTS, DENTAL STUDENTS, PATIENTS AND ON HIS COPYRIGHTED WEBSITE. THE SMILE IMAGES WILL NOT HAVE MY NAME ASSOCIATED WITH THEM.

APPOINTMENTS: ONCE AN APPOINTMENT HAS BEEN MADE, PLEASE REMEMBER THIS TIME HAS BEEN RESERVED FOR YOUR EXCLUSIVE USE. A MINIMUM CHARGE MAY BE MADE FOR CANCELLED APPOINTMENT WITHOUT PRIOR NOTIFICATION OF AT LEAST 24 HOURS.

INSURANCE: AS A SERVICE TO YOU, OUR OFFICE WILL SUBMIT TO YOUR INSURANCE COMPANY, FEES FOR SERVICES RENDERED. THE PATIENT IS ULTIMATELY RESPONSIBLE FOR THAT PORTION OF THE FEE WHICH IS NOT PAID BY THE INSURANCE COMPANY.

I CERTIFY THAT I HAVE READ AND UNDERSTAND BOTH SIDES OF THIS FORM. I ACKNOWLEDGE THAT MY QUESTIONS, IF ANY, ABOUT INQUIRIES SET FORTH ABOVE HAVE BEEN ANSWERED TO MY SATISFACTION. I WILL NOT HOLD MY DENTIST, OR ANY OTHER MEMBER OF HIS STAFF, RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM.

INSURANCE ASSIGNMENT AND RELEASE:

I AUTHORIZE DR. SUPOWITZ AND/OR ANY PROVIDERS OF SERVICES IN THIS OFFICE TO RELEASE THE INFORMATION REQUIRED TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS. I AUTHORIZE PAYMENT DIRECTLY TO DR. SUPOWITZ OF INSURANCE BENEFITS OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED.

SIGNATURE OF PATIENT _____ DATE _____

SIGNATURE OF RESPONSIBLE PARTY _____ DATE _____

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