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#

PHARMACY NAME: ____________________________ PHONE NO.____________________________

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
_______ALLERGIES TO MEDICINE OR DRUGS
____
_______OTHER ALLERGIES__________________
_______HEART ATTACK (M.I.)
_______HEART CONDITION __________________
_______HEART MURMUR
_______HIGH BLOOD PRESSURE
_______LOW BLOOD PRESSURE
_______CARDIAC PACEMAKER
_______ARTIFICIAL HEART VALVE
_______SHORTNESS OF BREATH
_______BRUISE EASILY
_______SWELLING OF ANKLE
_______STROKE
_______RHEUMATIC FEVER
_______ANEMIA
_______BLEED EXCESSIVELY
_______BLOOD THINNER (COUMADIN, ASPIRIN, PLAVIX, TICLID)
_______FAINTING OR DIZZINESS
_______MIGRAINE HEADACHES
_______ARTIFICIAL JOINT (HIP, KNEE, etc.)

_______EPILEPSY, SEIZURES
_______BLOOD TRANSFUSIONS
_______HEPATITIS A B C (CIRCLE)
_______CANCER
_______CHEMOTHERAPY
_______RADIATION THERAPY
_______TRANSPLANTS
_______ARTHRITIS, RHEUMATISM
_______STEROIDS (CORTISONE)
_______BISPHOSPHONATE (FOSAMAX, ACTONEL, BONIVA)
_______DIABETES
_______GLAUCOMA
_______ASTHMA
_______LUNG DISEASE (i.e EMPHYSEMA)
_______TUBERCULOSIS
_______STOMACH ULCERS
_______PSYCHIATRIC/PSYCHOLOGICAL CARE
_______SINUS PROBLEMS
_______COLD SORES
_______HERPES
_______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 DRS. SUPOWITZ PERMISSION FOR VISUAL IMAGES OF MY SMILE (TEETH AND LIPS ONLY, NOT FULL FACE) OBTAINED IN CONNECTION WITH MY DENTAL EXAMINATION AND/OR TREATMENT TO BE UTILIZED FOR EDUCATIONAL PURPOSES PRIMARILY IN THEIR OFFICE, BUT MAY BE UTILIZED FOR EDUCATIONAL PRESENTATIONS TO DENTISTS, DENTAL STUDENTS, PATIENTS AND ON THEIR COPYRIGHTED WEBSITE AND/OR SOCIAL MEDIA. THE SMILE IMAGES WILL NOT HAVE MY NAME ASSOCIATED WITH THEM.

APPOINTMENTS: ONCE AN APPOINTMENT HAS BEEN MADE, PLEASE REMEMBER THAT THIS TIME HAS BEEN RESERVED FOR YOUR EXCLUSIVE USE. A CHARGE MAY BE MADE FOR A 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 UTLIMATELY 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 DRS. SUPOWITZ, OR ANY OTHER MEMBER OF THEIR STAFF, RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM.

INSURANCE ASSIGNMENT AND RELEASE:
I AUTHORIZE DRS. 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 DRS. SUPOWITZ OF INSURANCE BENEFITS OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED.

SIGNATURE OF PATIENT ____________________ DATE__________

SIGNATURE OF RESPONSIBLE PARTY____________________ DATE__________

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AESTHETIC , RESTORATIVE AND IMPLANT DENTISTRY

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