

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 WE 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	_____ BISPHOSPHONATE (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, ELIQUIS, XARELTO)	_____ 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 ACKNOWLEDGE THAT I HAVE RECEIVED, OR HAVE BEEN OFFERED THE OPPORTUNITY TO RECEIVE, A COPY OF THIS PRACTICE'S NOTICE OF PRIVACY PRACTICES, WHICH IS ALSO AVAILABLE AT OUR OFFICE AND ON OUR WEBSITE.

VISUAL IMAGES: I GIVE DR. 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. 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 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 DENTISTS, 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 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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