

# Health History Form



American Dental Association  
www.ada.org

E-mail: \_\_\_\_\_ Today's Date: \_\_\_\_\_

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: Last First Middle	Home Phone: <i>Include area code</i> ( )	Business/Cell Phone: <i>Include area code</i> ( )
Address: Mailing address	City:	State: Zip:
Occupation:	Height:	Weight: Date of birth: Sex: M F
SS# or Patient ID:	Emergency Contact:	Relationship: Home Phone: Cell Phone: ( ) ( ) <i>Include area codes</i>

If you are completing this form for another person, what is your relationship to that person?

Your Name \_\_\_\_\_ Relationship \_\_\_\_\_

**Do you have any of the following diseases or problems:** (Check DK if you Don't Know the answer to the question) Yes No DK

Active Tuberculosis .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Persistent cough greater than a 3 week duration .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cough that produces blood.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Been exposed to anyone with tuberculosis .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.**

## Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	No	DK		Yes	No	DK
Do your gums bleed when you brush or floss? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have earaches or neck pains? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw? ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does food or floss catch between your teeth? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you brux or grind your teeth? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your mouth dry? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have sores or ulcers in your mouth? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any periodontal (gum) treatments? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear dentures or partials? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had orthodontic (braces) treatment? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you participate in active recreational activities? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any problems associated with previous dental treatment? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a serious injury to your head or mouth? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your home water supply fluoridated? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of your last dental exam:			
Do you drink bottled or filtered water? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What was done at that time?			
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY				Date of last dental x-rays:			
Are you currently experiencing dental pain or discomfort? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

What is the reason for your dental visit today?

How do you feel about your smile?

## Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No	DK		Yes	No	DK
Are you now under the care of a physician? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a serious illness, operation or been hospitalized in the past 5 years? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physician Name: _____ Phone: <i>Include area code</i> ( )				If yes, what was the illness or problem?			
Address/City/State/Zip:				Are you taking or have you recently taken any prescription or over the counter medicine(s)? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you in good health? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:			
Has there been any change in your general health within the past year? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
If yes, what condition is being treated?				_____			
Date of last physical exam:				_____			

**Medical Information** Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

<i>(Check DK if you Don't Know the answer to the question)</i>	Yes	No	DK		Yes	No	DK
Do you wear contact lenses? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you use controlled substances (drugs)? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you use tobacco (smoking, snuff, chew, bidis)? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED			
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you drink alcoholic beverages? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date Treatment began: _____				If yes, how much alcohol did you drink in the last 24 hours? _____			
				If yes, how much do you typically drink in a week? _____			
				<b>WOMEN ONLY</b> Are you:			
				Pregnant? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Number of weeks: _____			
				Taking birth control pills or hormonal replacement? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Nursing? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Joint Replacement.** Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? .....

Date: \_\_\_\_\_ If yes, have you had any complications? .....

<b>Allergies</b> - Are you allergic to or have you had a reaction to:	Yes	No	DK		Yes	No	DK
To all <b>yes</b> responses, specify type of reaction.				Metals _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Local anesthetics _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Latex (rubber) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Iodine _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever/seasonal _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives, or sleeping pills _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Animals _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Food _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Codeine or other narcotics _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

Yes	No	DK	Yes	No	DK	Yes	No	DK	Yes	No	DK
Heart murmur .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic pain .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapse .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusion .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Type I or II .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valves .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, date: _____				Eating disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Malnutrition .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular disease .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS or HIV infection .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal disease .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angina .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G.E. Reflux/persistent heartburn .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arteriosclerosis .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune disease .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congestive heart failure .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coronary artery disease .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Systemic lupus erythematosus .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damaged heart valves .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, jaundice or liver disease .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells or seizures .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart defects .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disorders .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Chemotherapy/ Radiation Treatment .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, Specify: _____			
Rheumatic heart disease .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain upon exertion .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Abnormal bleeding .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? .....

Name of physician or dentist making recommendation: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you have any disease, condition, or problem not listed above that you think I should know about? .....

Please explain: \_\_\_\_\_

**NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.**

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. 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/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**FOR COMPLETION BY DENTIST**

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Smile Questionnaire

Name \_\_\_\_\_

Date \_\_\_\_\_

In order to evaluate your needs and expectations as accurately as possible, please help us by answering the following questions.

**Are you unhappy with the appearance of your teeth and smile?**      **Yes**      **No**

**Do you feel that your teeth are (please circle response)**

<b>Too small or short</b>	<b>Yes</b>	<b>No</b>
<b>Too long or large</b>	<b>Yes</b>	<b>No</b>
<b>Crooked or crowded</b>	<b>Yes</b>	<b>No</b>
<b>Misshaped (Uneven/Pointed)</b>	<b>Yes</b>	<b>No</b>
<b>Off Color</b>	<b>Yes</b>	<b>No</b>
<b>Chipped</b>	<b>Yes</b>	<b>No</b>

**Do you feel like your teeth stick out too much?**      **Yes**      **No**

**Are there spaces between your teeth that you do not like?**      **Yes**      **No**

**Is there too much or too little gum tissue showing when you smile?**

**Yes**      **No**

**Are there other dental issues not listed above that you would like to discuss or have treated?**      **Yes**      **No**

**If yes, Please explain** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**What would you like to change about your smile and how it would make you feel?** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Signature** \_\_\_\_\_

## Financial Agreement

In an effort to make our services as affordable as possible, we offer financing options through outside companies for qualified individuals. If interested, please ask our financial coordinator about the details.

In order for you to be able to make plans in advance to satisfy your treatment costs, we are introducing our collection policies in advance. These policies are as follow:

1. You are personally responsible for the full payment of all services rendered.
2. All co-payments are due and payable at the time the services are rendered.
3. We will discuss your treatment costs with you in advance and provide you with our best estimate of the portion of fees payable by your insurance company. However, you must keep in mind that the final decision as to the extent of your insurance benefits is made by your insurance company. Therefore, you are ultimately personally responsible for any portion of the costs not paid by your insurance provider(s).
4. We will bill your insurance company(s) for services rendered on your behalf and apply all the payments received to your account.
5. We will submit any procedures that require prior authorization to your insurance company(s) for approval. You may decide to wait for this approval prior to the procedure(s) being performed, or you may decide to undergo the treatment regardless. In either case, you are ultimately personally responsible for any portion of the costs not paid by your insurance provider(s). You must keep in mind that a prior approval is not a guarantee of payment by your insurance company and other factors such as the amount of benefits used may affect the final payment.

Signature:

I have read and understood the above policies and I agree with their consent as a condition of treatment. I accept full financial responsibility for all charges for services rendered to me, to my minor child or to the person for whom I have legal responsibilities. I understand that filing a claim to my insurance company(s) by me or by this office does not relieve me from my responsibility for the payment of all charges.

Name of Adult Patient, Parent/Guardian or Responsible Party

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Signature of Adult Patient, Parent/Guardian or Responsible Party

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Date: \_\_\_\_\_

## NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed. Please review it carefully. The privacy of your health information is important to us.

### **Uses and Disclosures of Health Information**

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment for you

**Payment:** We may use and disclose your health information to obtain payment for services we provide for you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation certification, licensing or credential activities.

**Your Authorization:** In addition to your use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any uses or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your healthcare information for any reason except those described in this notice.

**To your family and friends:** We must disclose your health information to you, as described in the patient rights sections of this notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons involved in care:** We may use and disclose your health information to notify or assist in the notification of (including identifying or locating) a family member, a personal representative or another person responsible for your care, of your location, your general condition or death. If you are present, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, x-rays or other similar forms of health information.

**Marketing health-related services:** We will not use your health information for marketing communications without your written authorization.

**Required by law:** We may use and disclose your health information when we are required by law to do so.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail, texts, postcards or letters)

**Signature:** By signing this form, I acknowledge that I had full opportunity to read and consider the contents of this office's privacy practices. I understand that by signing this consent form, I am giving consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

**Name** \_\_\_\_\_

**Date** \_\_\_\_\_

**Designation of Disclosure:**

There may be times when you want us to discuss your dental care or payment issues with a family member or close friend. Please list the names and relationships of all such persons below.

**Name** \_\_\_\_\_

**Relationship** \_\_\_\_\_

**Name** \_\_\_\_\_

**Relationship** \_\_\_\_\_

**Name** \_\_\_\_\_

**Relationship** \_\_\_\_\_