Today's Date:

Health History Form

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	Date of Birth:

Emergency Contact:	Relationship:	Home Phone: include area code ( )	Cell Phone: include area code ( )

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

Your Name Relationship

Dental Information *For the following questions please mark (X) your responses to the following questions.* **(Check DK if you Don't Know).**

	Yes	No	DK
Do your gums bleed when you brush or floss?			
Have you ever been told you have gum disease?			
Does food or floss catch between your teeth?			
Are your teeth sensitive to cold, heat, sweet or pressure?			
Have you noticed any loosening of teeth?			
Do you clench or grind your teeth?			
Do you have pain in or around your ears?			
Do you have swelling or lumps in your mouth?			

How often do you use dental floss? _____

How often do you brush? _____

	Yes	No	DK
Have you ever had any complications following dental treatment?			
Is there anything about having dental treatment that bothers you?			
Is there anything else that would be valuable for me to know?			

If yes, please explain: _____

Are you satisfied with the appearance of your teeth?			
Are you currently experiencing dental pain or discomfort?			

Date of your last dental exam:

Were x-rays taken?			

What was done at that time?

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *For the following questions please mark (X) your responses to the following questions.* ***(Check DK if you Don't Know)***

	Yes	No	DK
Are you now under the care of a physician?			

Physician Name: Phone: include area code ( )

Address/City/State/Zip:

Are you in good health?			
Has there been any change in you general health within the past year?			

If yes, what condition is being treated?

Date of last physical exam:

Have you had a serious illness, operation or been Hospitalized in the past 5 years?			

If yes, what was the illness or problem?

	Yes	No	DK
Are you taking anticoagulant (blood thinners) such as Aspirin, Coumadin or Plavix?			
Are you taking or have you recently taken any prescription or over the counter medicine(s)?			

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

_____

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