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: *Include area code* ( ) Business/Cell Phone: *Include area code* ( )

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: ( ) *Include area codes*

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	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

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
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

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
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 your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

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:

Medical Information

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

(Check DK if you Don't Know the answer to the question)	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: _____ If yes, have you had any complications? _____			
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?	☐	☐	☐
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?	☐	☐	☐
Date Treatment began: _____			

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink In a week? _____			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

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

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

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: _____			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐

	Yes	No	DK
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐

	Yes	No	DK
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: _____			
Sleep disorder	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify: _____			
Recurrent Infections	☐	☐	☐
Type of infection: _____			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

	Yes	No	DK
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐

Name of physician or dentist making recommendation: _____ Phone: _____

	Yes	No	DK
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: _____

GENERAL DENTISTRY INFORMED CONSENT

Dentist: _____ Patient: _____

1. **WORK TO BE DONE**: I understand that I am having the following work done [Indicate all services being provided]: Fillings ( ) Bridges ( ) Crowns ( ), X-rays ( ) Extractions ( ) Impacted teeth removal ( ) Root Canals ( ) Dentures ( ) Other ( ) _____.
   Patient Initials _____

2. **DRUGS AND MEDICATION:** I understand that antibiotics, analgesics and other medications may cause allergic reactions causing redness and swelling of tissue, pain, itching, vomiting, and/or anaphylactic shock. I have advised my dentist of any and all medications I am currently taking, including but not limited to prescription medications, over-the-counter medications, herbal remedies, and alternative medications. I further understand that failure to advise that failure to advise my dentist of any medications I am taking prior to starting to dental work may have unforeseen negative consequences for me.
   Patient Initials _____

3. **CHANGES IN TREATMENT PLAN:** I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discoverable during previous examinations. For example, root canal therapy may be necessary following routine restorative procedures. I give my permission to my dentist to make any/all changes and additions as necessary.
   Patient Initials _____

4. **REMOVAL OF TEETH:** Alternatives to removal have been explained to me (root canal therapy, crowns, periodontal surgery, etc.), and I authorize the dentist to remove the following teeth: _____, and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved with extraction, some of which are pain, swelling, spread of infection, dry socket, and loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time, and fractured jaw. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost for which is my responsibility.
   Patient Initials _____

5. **CROWNS, BRIDGES AND CAPS:** I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crowns, bridge, or cap (including shape, fit, and color) will occur only before final cementation. It is also my responsibility to return for permanent cementation within 21 days from initial tooth preparation. Excessive delays may allow for tooth movement which may necessitate a remake of the crown, bridge, or cap. In such instances, I understand that there will be additional charges for remakes due to my delaying permanent cementation.
   Patient Initials _____

6. **ENDODONTIC TREATMENT (ROOT CANAL):** I realize there is no guarantee that root canal therapy will save my tooth, and that complications can occur from the treatment, and that occasionally root canal filling material may extend through the tooth which does not necessarily affect the success of the treatment. I understand that endodontic files are very fine instruments and stresses from their manufacture can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary

following root canal treatment (apicoetomy). I understand that the tooth may be lost in spite of all efforts to save it.
Patient Initials _____

7. **PERIODONTAL LOSS (TISSUE AND BONE):** I understand that if I am being treated for periodontal disease, this means I have a serious condition, causing gum and bone inflammation or loss and that it can ultimately lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that any dental procedure may have a future adverse effect on my periodontal condition.
Patient Initials _____

8. **FILLINGS:** I understand that care must be taken when chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that increased sensitivity is a common effect of a newly placed filling.
Patient Initials _____

9. **DENTURES:** I understand the wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating are common problems associated with dentures. Immediate dentures (placement of denture immediately after extractions) may be painful. In addition, immediate dentures often require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fitted dentures. If a remake is required due to my delay of 30 days or more, there may be additional charges assessed against me.
Patient Initials _____

I understand that dentistry is an inexact science and that therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment(s) which I have requested and authorized.

I hereby authorize any of the doctors or dental assistants or auxiliaries to proceed with and perform the dental restorations and treatments indicated above and as explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen or undiagnosed circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I may be responsible for payment of the dental fees.

Signature of Patient: _____ Date: _____

Signature of Dentist: _____ Date: _____

Broken Appointment policy notice

We have more patients who need dental care than we have room in our daily schedule to provide. When a patient does not show up for their appointment or cancels too close to their scheduled time, we are unable to fill this appointment time with another patient who desperately needs dental care. This policy is our attempt to ensure that both you and our other patients receive the dental care that you need.

Broken Appointments: Patients are only allowed THREE broken appointment in a 12 month time period.

- Broken appointments are any time you are scheduled for an appointment and you do not show for that appointment.

- Late cancelations are considered broken appointments. If you need to cancel your appointment, we ask that you please call us at least 24 hours before your appointment time.

- Late arrivals are also considered broken appointments. If you do not arrive by 10 minutes after the start time of your appointment, it will be given to another patient.

If for any reason, a patient misses their appointment or cancels late for a FOURTH time within a 12 month period, they will not be scheduled for another appointment due to patient-doctor relationship has Ended. However, these patients are still welcome to receive their dental care from us on emergency only. Patients can either call us in the morning for a "same day appointment," or they may come to our clinic as a "walk-in patient." We always do our best to work our walk-in patients into the schedule as long as it does not interfere with the care of previously scheduled patients; but please understand there is no guarantee that you will receive an appointment as a "same day appointment" or "walk-in."

Patient Signature _____ Date_____

Missing or canceling appointment policy

We value you as our patient and need your cooperation with keeping appointments so that we can provide your care. Missing or late canceling an appointment means we are unable to fill this appointment time with another patient who desperately needs care. Our policy requires:

• Timely Cancellations: If you need to cancel or reschedule your appointment, you must give us at least 24 hours' notice. Cancellations made with less than 24 hours' notice will be considered a missed appointment.

Initials _____

• On Time Arrivals: If you are more than 10 minutes late to your appointment, we will give your appointment away to another patient. This will be considered a missed appointment.

Initials_____

• Compliance: Patients are only allowed THREE missed appointment in a 12 month period. After the FOURTH missed appointment, you will not be scheduled appointments, but are welcome to use our clinic as a "walk-in" patient.

Initials_____

Your help in keeping your appointments enables us to provide better and timelier care for all our patients.

Signing below certifies, I the patient or guardian have been notified and understand the Broken appointment policy and agree to the terms.

Patient or Parent/Guardian Signature _____

Date _____