Paoli Family Dentistry - Health History Form

Date _____

Name_____ Home Phone (____)_____ Cell (____)_____ Work (____)_____

Address_____ City _____ State _____ Zip Code_____

Occupation_____ Date of Birth _____Age_____ Sex ☐ M ☐ F Martial Status_____

SS#_____ Email Address_____ Pharmacy_____

Emergency Contact_____ Relationship_____ Phone (____)_____

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

Whom may we thank for referring you to our office?_____

RESPONSIBLE PARTY AND/OR INSURANCE INFORMATION

RESPONSIBLE PARTY AND/OR INSURED PERSON'S FULL NAME	EMPLOYED BY:	DATE OF BIRTH
SOCIAL SECURITY NUMBER	RELATIONSHIP TO PATIENT	WORK PHONE
INSURANCE COMPANY NAME	ID#	GROUP OR LOCAL NUMBER

If you have secondary insurance, please complete the following:

INSURED PERSON'S FULL NAME	EMPLOYED BY:	INSURED PERSON D.O.B
SOCIAL SECURITY NUMBER	RELATIONSHIP TO PATIENT	WORK PHONE
INSURANCE COMPANY NAME	ID#	GROUP OR LOCAL NUMBER

I authorize insurance payment directly to Paoli Family Dentistry. I understand that I am ultimately responsible for all charges whether paid by my insurance or not. I authorize Paoli Family Dentistry to release information required to secure the benefits. I understand I am responsible for my insurance co-payment at the time services are rendered.

Signature of Responsible Party:_____

DENTAL INFORMATION

YES	NO	DON'T KNOW		YES	NO	DON'T KNOW	
☐	☐	☐	Do your gums bleed when you brush?	☐	☐	☐	Have you ever had orthodontic treatment?
☐	☐	☐	Are your teeth sensitive to cold, hot, sweets, or pressure?	☐	☐	☐	Do you have headaches, earaches or neck pains?
☐	☐	☐	Have you had any periodontal (gum) treatments?	☐	☐	☐	Do you wear removable dental appliances?
☐	☐	☐	Have you had any serious/difficult problem associated with any previous dental treatment? If so, explain_____				

How would you describe your current dental problem?_____

Family history of Periodontal Disease? Circle: Yes or No If so, relationship?_____

Date of your last dental exam_____ Date of last hygiene appt _____Name of last dentist_____

What was done at that time? _____Date of last dental x-rays_____

How do you feel about the appearance of your teeth?_____

Do you have any problems with bad breath?_____

MEDICAL INFORMATION

YES	NO	DON'T KNOW	
☐	☐	☐	Are you in good health?
☐	☐	☐	Has there been any changes in your health within the past year?
☐	☐	☐	Are you under the care of a physician? If so, what are the conditions being treated?_____
			_____Date of last exam_____
			Physician_____
			Name Phone Address City/State/Zip
☐	☐	☐	Have you ever had any serious illness, operation, or been hospitalized in the past five years? If so, what was the illness or problem?_____
☐	☐	☐	Do you drink soft drinks / sports drinks? If yes how many per day? _____
☐	☐	☐	Have you had treatment for drug or alcohol related problems?
☐	☐	☐	Do you use tobacco (smoking or chew)? How many years have or did you use tobacco? _____ How much tobacco did you use per day? _____
☐	☐	☐	Have you are had a joint replacement? If so, what joint?_____ What date?_____

Are you taking any medications (Prescription or Over-the-Counter)?
If yes, for what purposes? PLEASE LIST BELOW

NAME OF DRUG	PURPOSE

Are you allergic to or have you had a reaction to?	YES	NO	DON'T KNOW	
Local Anesthetics	☐	☐	☐	
Antibitoics	☐	☐	☐	(specify)_____
Barbiturates, sedatives, or sleeping pills	☐	☐	☐	
Sulfa Drugs	☐	☐	☐	
Codeine or other narcotics	☐	☐	☐	
Latex	☐	☐	☐	
Iodine	☐	☐	☐	
Hay fever/seasonal	☐	☐	☐	
Metal	☐	☐	☐	

Food Allergy? (Specify)_____

Other allergies or allergic reactions (specify)_____

Please (x) a response to indicate if you have or have had any of the following diseases or problems

	YES	NO	DON'T KNOW
Abnormal Bleeding	☐	☐	☐
AIDS or HIV	☐	☐	☐
Anemia	☐	☐	☐
Arthritis	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐
Asthma	☐	☐	☐
Blood transfusion If yes, date_____	☐	☐	☐
Cancer/Chemotherapy/Radiation	☐	☐	☐
Cardiovascular diseases? If yes, please specify	☐	☐	☐
_____Angina Pectoris			
_____ Heart murmur			
_____Bypass/Cardiac Surgery			
_____Mitral Valve Prolapse			
_____Pacemaker			
_____Rheumatic fever			
_____Artificial valves			
_____Heart attack If yes, date			
_____Stroke. If yes, date_____			
Chest Pain upon exertion	☐	☐	☐
Chronic Pain	☐	☐	☐
Disease, drug, or radiation-induced immunosuppression	☐	☐	☐
Diabetes. If yes, please specifiy	☐	☐	☐
_____Type 1 (insulin dependent) _____ Type II			
Dry mouth	☐	☐	☐
Eating disorder. If yes, please specify_____	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Gastrointestinal Disease	☐	☐	☐
G.E. reflux/persistent heartburn	☐	☐	☐

	YES	NO	DON'T KNOW
Hemophilia	☐	☐	☐
Hepatitis, Jaundice, or Liver Disease	☐	☐	☐
Reccurent Infection	☐	☐	☐
If yes, indicate type of infection_____			
High Blood Pressure	☐	☐	☐
Mental Health disorder	☐	☐	☐
Night Sweats/Menopausal	☐	☐	☐
Neurological disorders	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistant swollen glands	☐	☐	☐
Respiratory problems. If yes, please specify: ___Emphysema ___Bronchitis, etc.	☐	☐	☐
Severe headaches/migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted Disease	☐	☐	☐
Sinus Trouble	☐	☐	☐
Sores or ulcers in the mouth	☐	☐	☐
Systemic Lupus Erythematosus	☐	☐	☐
Tuberculosis	☐	☐	☐
Thyroid problems	☐	☐	☐
Ulcers	☐	☐	☐
Excessive urination / thirst	☐	☐	☐
Glaucoma	☐	☐	☐
Have you ever been told you need to premedicate before dental appt?	☐	☐	☐
Are you pregnant?	☐	☐	☐
Are you taking birth control pills?	☐	☐	☐

Do you have any disease not listed above that you think we should know about? Please explain:

_____

I certify that I have read and understand the above. 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 because of errors or ommission that I may have made in the completion of this form.

SIGNATURE OF PATIENT/LEGAL GUARDIAN DATE Signature of Dentist

Medical Financial Consent:

The information I have given is correct to my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform necessary dental services deemed appropriate by the Doctor. I also understand the use of anesthetic agents embodies a certain risk. I accept that responsibility for payments of dental services are mine; due and payable at the time of services are rendered unless financial arrangements have been made. In the event of default, I (We) promise to pay legal interest, collection costs and reasonable attorney fees as required to collect on the indebtness.

SIGNATURE OF PATIENT/LEGAL GUARDIAN DATE Signature of Dentist