Health History Form

Dentistry by Design
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Dental History

First Name: _____ Last Name: _____ Date of Birth: _____
Street Address: _____ City/ State: _____ Zip Code: _____
Email: _____ Cell Phone: _____

Reason for today's visit: _____

Check if you have or have had problems with any of the following:

O Bleeding Gums
O Periodontal Treatment
O Clicking or Popping Jaw
O Sensitivity to Sweets
O Loose Teeth of Broken Fillings
O Food Collection Between Teeth
O Mouth Odors/Bad Taste
O Grinding Teeth
O Orthodontic Treatment
O Sensitivity when Bitting
O Fear of Dental Treatment
O Sensitivity to Hot and Cold
O Oral Surgery
O Cold Sores or Other Lesions
O Restless Sleep/Snoring

Are you satisfied with the appearance of your teeth? ..... Yes / No
Would you like a whiter smile? ..... Yes / No
Would you like straighter teeth? ..... Yes / No

Medical History

Are you currently under physician care? **YES / NO**
If yes, explain: _____

Physician's Name: _____ Phone Number: _____

Have you had any serious illness or operations? **YES / NO**
If yes, explain: _____

WOMEN: ***Pregnant? YES / NO*** ***If yes, how many months? ___*** ***Nursing? YES / NO***

Check if you have or have had any of the following:

Y/N Anemia
Y/N Asthma
Y/N Herpes
Y/N Hepatitis
Y/N HIV / AIDS
Y/N Skin Rash
Y/N Stroke
Y/N Jaw Pain
Y/N Tonsillitis
Y/N Ulcer
Y/N Tuberculosis
Y/N Cancer / Tumors
Y/N Pacemaker
Y/N Arthritis/ Rheumatism
Y/N Back Problems
Y/N Chemotherapy
Y/N Cough up Blood
Y/N Headaches / Migraines
Y/N Liver Disease
Y/N Psychiatric Care
Y/N Fainting / Dizziness
Y/N Radiation Treatment
Y/N Kidney Disease
Y/N Diabetes
Y/N Artificial Heart Valves
Y/N Hemophilia / Abnormal Bleeding
Y/N Circulatory Problems
Y/N Diabetes
Y/N Swelling of Feet / Ankles
Y/N Heart Murmur
Y/N Tobacco Habit
Y/N Chemical Dependency
Y/N Rheumatic / Scarlet Fever
Y/N Rapid weight loss / gain
Y/N Shortness of Breath
Y/N Thyroid Problems
Y/N Low Blood Pressure
Y/N High Blood Pressure
Y/N Acid Reflux
Y/N Epilepsy / Seizures
Y/N Heart Problems
Y/N Venereal Disease
Y/N Persistent Cough
Y/N Cortisone Treatment
Y/N Respiratory Disease
Y/N Sinus Problems
Y/N Cholesterol
Y/N Autoimmune Disorder
Y/N Blood Transfusion
Y/N Heart Surgery
Other: _____

ALLERGIES:

Medication List

Medication / Supplement:	*Dosage:*	*Why:*

Aesthetics

Please indicate any areas of concern for you:

O Forehead Lines
O Frown Lines
O Crow's Feet

O Lip appearance and texture
O Thin Lips
O Skin appearane anf texture

Insurance Information

Insurance Name: _____
Insurance Phone Number: _____
Insurance Mailing Claims Address: _____
_____

Subscriber's Name: _____
ID Number: _____
Group Name: _____
Group Number: _____

Note: Both Doctor and Patient are encouraged to discuss 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 the information for treating me. I acknowledge that my questions, if any, about the 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 completion of this form.

_____ _____

Patient or Parent/Guardian Signature *Date*