Patient Health History Form

Patient's Name:

Today's Date:

Physician's Name:

Title:
Name:
Spouse's Name:
Address:
City:
Zip:
Phone:
Cell Phone:
Work Phone:
Birth Date:
Employer:
Social Security #:

Primary Insurance Co.:
Insured Subscriber's Name:
Insured Subscriber's Birth Date:
Insured Subscriber's SS#/ID#
Insured Subscriber's Employer (even if retired):

Secondary Insurance Co.:
Insured Subscriber's Name:
Insured Subscriber's Birth Date:
Insured Subscriber's SS#/ID#

I authorize this office to act as my agent in helping me obtain payment from my dental insurance company(ies). And I understand that medical insurance is not billed in this office

Who is financially responsible for bills?

How will the bill be paid today?

Date of last professional cleaning:
Frequency of professional cleanings:
Do you smoke?
Do you chew tobacco?
Have you smoked or chewed in the past?
If so, how many years?
How much?

Is it difficult to open your mouth as wide as you would like?
Does your jaw click when you chew?
Do you clench or grind your teeth?
Have you ever had gum surgery?
Are you pregnant?
If so, what is your due date?

Please list all surgeries that you have had in the past five years:

Do you have any medication allergies or medications you can't take?

Please list all current medications with dosage & include all supplements:

Do you have or have you ever been told you had the following:

- Heart Disease
- Alcoholism
- Bleeding Disorders
- Diabetes
- Tuberculosis
- Asthma
- Liver Disease or Hepatitis
- Glaucoma
- TMJ Dysfunction (popping jaw joints)
- Joint Replacement
- Cancer
- Angina or Chest Pain
- High Blood Pressure
- Anemia
- Osteoporosis
- Thyroid Problems
- Emphysema
- Epilepsy or Seizures
- Kidney Disease
- Immune Problems or HIV
- Stomach Problems or Ulcers