Health History Form - Adult

Patient Information

Patient's Name: ____________ Age: ________ Birth date: ____________

Home PH # ____________ Cell Ph # ____________ Email Address: ____________

Address: ____________ City: ____________ State: ________ Zip: ________

Social Security #: ____________ Employer: ____________ Occupation: ____________

Time at current residence: ________ Time at current employer: ________ Marital Status: ____________

Who may we thank for referring you to our office? ____________

Spouse/Additional Contact Information

Name: ____________ Home Phone # ____________ Cell Phone # ____________

Address: ____________ City: ____________ State: ________ Zip: ________

Time at this address: ____________

Social Security #: ____________ Birth date: ____________ Relationship to Patient: ____________

Employer: ____________ Occupation: ____________ No. of years employed: ____________

Dental Insurance Information – Please Provide All Information In Order To accurately verify benefits

Insured Name: ____________ Insured's SS#: ____________ Insured's DOB: ____________

Insurance member ID: ____________ Group #: ____________ Insurance Co: ____________

Insurance Co. Address: ____________

Phone: ____________ Insured's Employer: ____________

Do you have dual coverage? ☐Yes ☐No If yes: Insured Name: ____________ Insured SS# ____________

Insured member ID: ____________ Group #: ____________ Insurance Co: ____________

Insured's Employer: ____________ Insurance Co. Address: ____________

Medical/Dental History

Physician's Name: ____________ Phone: ____________

Dentists Name: ____________ Phone: ____________

☐Yes ☐No Are you currently under any medical treatment? If So What Kind? ____________

☐Yes ☐No Do you have pain, clicking, and/or popping noises in the jaw?

☐Yes ☐No Are you aware of either clenching or grinding of teeth? History of Night guard? ☐Yes ☐No

☐Yes ☐No Do you have frequent headaches? How often? ____________

☐Yes ☐No Do you have ear problems? (Aches, ringing, dizziness, fullness)

☐Yes ☐No Do you have difficulty breathing through the nose?

☐Yes ☐No Do you have habits such as nail biting, finger or thumb sucking, lip or cheek biting?

☐Yes ☐No Do you have speech problems, or are you in speech therapy?

☐Yes ☐No Have you had your tonsils and/or adenoids removed?

☐Yes ☐No Has there been any history of: ☐Joint swelling ☐Asthma ☐TB ☐Aids ☐HIV ☐Kidney ☐Liver Condition ☐Epilepsy ☐Rheumatic fever ☐Other major illnesses? ____________

☐Yes ☐No Do you bleed easily? Anemic: ☐Yes ☐No

☐Yes ☐No Is there a tendency to faint or become dizzy? Please explain ____________

☐Yes ☐No Do you have allergies? (LATEX, Sulphur, penicillin, novocaine, etc.) ____________

☐Yes ☐No Are you currently taking any medication? List: ____________

☐Yes ☐No Do you have a heart condition? Do you pre-medicate? ☐Yes ☐No Cardiologist: ____________

☐Yes ☐No Are you currently pregnant? If yes, what is the due date? ____________

☐Yes ☐No Do you have a history of Calcium replacement therapy? (Fosamax or Boniva) If yes, for how long? ____________

☐Yes ☐No Have you been diagnosed with sleep apnea? If so do you use CPAP machine? ☐Yes ☐No

☐Yes ☐No Do you smoke or chew tobacco? Quantify Usage ____________

☐Yes ☐No History of facial trauma or injuries to the teeth? Explain ____________

☐Yes ☐No Have you had any permanent teeth other than wisdom teeth extracted?

☐Yes ☐No Have we treated any other family members? Who: ____________

Any other medical concerns not listed above: ____________

Signature: ____________ Date: ____________