Health History Form – Adult

Patient Information

Patient's Name:_________________________ Age: ________ Birth date: ________________

Home Phone#: ____________________ Cell Phone#:____________________ Email: ____________________

Address:______________________________ City: ______________________ State:______ Zip: ______

Social Security #:____________________ Employer: ____________________Occupation:________________

Time at current residence: __________ Time at current employer: ___________ Marital Status: ________________

Whom 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 residence: ____________ 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 insurance benefits

Insured's 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's Name: ________________________ Insured's SS#: ____________________ Insured's DOB:__________

Insurance Member ID:____________________ Group#:________________Insurance Co: ____________________

Insurance Co. Address: ____

Phone: ______________________ Insured's Employer: ______________________________________

Medical/Dental History

Physician's Name: ________________________________ Phone: ___________________

Dentist's 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?

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

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

☐Yes ☐No Has there been a history of growth hormone therapy? If so when and how long? ________________

☐Yes ☐No Do you have a heart condition? Cardiologist:_________________________

☐Yes ☐No Does the patient pre-medicate?

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

☐Yes ☐No Do you have a history of calcium replacement therapy?(Flosamax or Boniva) if yes, 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:___________________________