Medical Alert	Condition	Pre-med	Allergies	Anesth

Health History Form

Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental and medical health.

Patient Information

Date ______________________

Name: Last ____________________ First ____________________ Nickname ______________
Street ____________________________________ City ______________________________
State ______________ Zip ________ Sex M F DOB ____/____/____ Age ________
Soc. Security No. ____
Phone (Home) ______________________ (Cell) __________________________________
(Work) ___________________________ Driver's License No. ___________________________
E-mail Address ____
Employer __________________________________ Occupation _________________________
Work Address ____
Who may we thank for referring you? ____
Previous Dentist _____________________________ Reason for changing ________________

Responsible Party Information (if different)

Name ____________________________________ Relationship to Patient _________________
Address ____
Phone (Home) ______________________ (Cell) __________________________________
(Work) ___________________________ Driver's License No. ___________________________

Emergency Notification Information

Name ____________________________________ Relationship to Patient _________________
Address ____
Phone (Home) ______________________ (Cell) __________________________________

Physician Information

Personal Physician ____________________________ Phone ____________________________
Street ______________________________ City ______________________ Zip __________
Physician Fax No. ______________________ Medical Insurance Co. ______________________
Policy No. ___________________________ Medical Insurance Co. Phone No. ______________

I authorize payment directly to Steven Hechtman, DDS of the insurance benefits and release of any information necessary for billing purposes.
I understand I am responsible for all charges for dental treatment.

____
Patient/Guardian Date

Dental Information

If new patient, date of your last dental exam ____________ Date of last dental x-rays ____________

Are you having any discomfort at this time? ______ If yes, please explain. ____________

____

Y N Have you ever been treated for gum disease?

Y N Do you use dental floss routinely?

Y N Do you have trouble getting numb?

Y N Have you had any problems or complications with previous dental treatment?

Do you have or have you ever had any of the following?

Y N Bleeding/sore gums

Y N Unpleasant taste/bad breath

Y N Burning tongue/lips

Y N Frequent blisters lip/mouth

Y N Swelling/lumps in the mouth

Y N Difficulty opening/closing

Y N Clicking/popping jaw

Y N Loose teeth

Y N Sensitivity to hot/cold/sweets

Y N Sensitivity to biting

Y N Catching food in teeth

Y N Clenching/grinding

Does dental treatment make you nervous? No Slightly Moderately Very

Is there anything else you would like us to know about your dental health, past dental experiences, or any questions you have about dental health? ____________

____

Family Medical History

Please circle any condition that applies to your parents.

Heart disease	Diabetes	Cancer ____________
Heart attack	Dentures/tooth loss	Gum disease
Stroke	High blood pressure	Alzheimer's disease

Medical Information

Please circle any condition that applies to you. If you don't know, please underline it.

Aspirin allergy	Penicillin allergy	Sulfa drug allergy
Birth control	Pregnant/pre-term birth	Heart problems ________
High blood pressure	Low blood pressure	Radiation treatment
Chemotherapy	Cancer ________	Bleeding problem
Heart valve replacement	Blood disorder	Diabetes
Stomach problems	Asthma	Glaucoma
Breathing problem	STD ________	HIV/AIDS
Fainting	Hepatitis	Kidney disease
Stroke	Thyroid disease	Artificial joint ________
Anxiety	Depression	Arthritis
Smoke/chew tobacco	Eating disorder	Substance abuse

Have you been hospitalized or had any operations within the last 12 months? If yes, please explain. ________

____

Please list medications/vitamins you are currently taking. ________

____

Are you currently under a physician's care? If yes, please explain. ________

____

Is there anything else you would like us to know about your medical history or condition? ________

____

Any other allergies not listed above. ________

____

Would you like to speak to the dentist privately about your medical information? Y N

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 or do not take because of errors or omissions that I may have made in the completion of this form.

____

Signature of Patient or Legal Guardian Date