PINES DENTAL
ASSOCIATES

Health History

PATIENT INFORMATION

DATE_____

NAME_____ E-MAIL_____ HT_____

ADDRESS_____ HOME PHONE_____ WT_____

CITY_____ ST____ ZIP_____ CELL PHONE_____

OCCUPATION_____ OFFICE PHONE_____

SS# _____ DOB_____ SEX M F MARITAL STATUS_____

RESPONSIBLE PARTY

NAME_____ DOB_____

ADDRESS_____ SS#_____

_____ CELL PHONE#_____

RELATIONSHIP TO PATIENT_____ E-MAIL_____

INSURANCE INFORMATION

NAME OF INSURED_____ DOB_____

INSURANCE COMPANY_____ SS# OR ID#_____

INSURANCE ADDRESS_____ PHONE#_____

EMPLOYER_____ GROUP#_____

RELATIONSHIP TO PATIENT _____

OTHER INSURANCE_____

PATIENT MEDICAL HISTORY

PRIMARY PHYSYCIAN_____ PHONE#_____ LAST EXAM_____
ARE YOU IN GOOD HEALTH?_____
ARE YOU BEEN TREATED FOR ANY CONDITION_____

HAVE YOU EVER BEEN TOLD YOU HAVE ONE OF THE FOLLOWING:

___ABNORMAL BLEEDING	___ASTHMA	___ALCOHOL ABUSE
___ALLERGIES	___ANEMIA	___ANGINA
___ARTIFICIAL JOINTS	___ARTHRITIS	___AIDS
___ARTIFICIAL HEART VALVES	___BACK PROBLEMS	___CANCER
___CHEMICAL DEPENDENCY	___CHEMOTHERAPY	___COLITIS
___COSMETIC SURGERY	___DIABETES	___EMPHYSEMA

___EPILEPSY
___HEART PROBLEMS
___HEPATITIS A
___HIGH BLOOD PRESSURE
___LOW BLOOD PRESSURE
___PSYCHIATRIC CARE
___SCARLET FEVER
___TUBERCULOSIS
___SLEEP DISORDER

___FAINTING/DIZZINES
___HEART MURMUR
___HEPATITIS B
___KIDNEY PROBLEMS
___MITRAL VALVE PROLAPSE
___RADIATION THERAPY
___STROKE
___ULCERS
___ OTHER

___GLAUCOMA
___HEADACHES
___HERPES
___LIVER DISEASE
___PACE MAKER
___RHEUMATIC FEVER
___THYROID PROBLEM
___SMOKING

DO YOU ŚNORE? _____ WAKE UP TIRED_____ STOP BREATHING WHILE SLEEPING____

MEDICATIONS_____

ARE YOU PREGNANT?_____ HOW MANY WEEKS?_____ NURSING_____

BIRTH CONTROL PILLS_____ TAKING BISPHOSPHANATES?_____

DO YOU SUFFER FROM ANY ALLERGIES? _____

ASPIRIN___ CODEINE___ ANESTHETICS___ PENICILLIN____

ANY OTHER NOT LISTED_____

HAVE YOU BEEN TREATED WITH ORAL BISPHOPHONATES LIKE **ALENDRONATE(FOSAMAX)** OR **RISENDRONATE (ACTONEL)** ? _____ OR ANY IV BISPHOSPHONATES LIKE **AREDIA** OR **ZOMETA**?

_____

DATE STARTED_____

DENTAL HISTORY

	YES	NO
DO YOUR GUMS BLEED WHEN BRUSH OR FLOSS ?	_____	_____
ARE YOUR TEETH SENSITIVE TO HOT OR COLD?	_____	_____
DOES FOOD OR FLOSS CATCH BETWEEN TEETH?	_____	_____
HAVE YOU HAD ANY PERIODONTAL TREATMENT?	_____	_____
DO YOU SUFFER FROM DRY MOUTH?	_____	_____
ARE YOU HAVING PAIN OR DISCOMFORT?	_____	_____
HAVE YOU HAD ANY PROBLEMS W/PREVIOUS TREATMENT	_____	_____
DO YOU SUFFER FROM HEADACHES OR EARACHES?	_____	_____
DO YOU HAVE ANY CLICKING OR POPPING OF JAW?	_____	_____
DO YOU GRIND YOUR TEETH?	_____	_____
HAVE YOU HAD ANY TRAUMA TO HEAD OR MOUTH?	_____	_____
ARE YOU HAPPY WITH THE WAY YOUR TEETH LOOK?	_____	_____

WHAT IS THE REASON FOR THE VISIT TODAY? _____

_____

DATE OF LAST DENTAL EXAM_____ LAST CLEANING_____

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE AND THE INFORMATION GIVEN ON THIS FORM IS ACCURATE. I UNDERSTAND THE IMPORTANCE OF A TRUTHFUL HEALTH AND DENTAL HISTORY AND THAT MY DENTIST AND HIS STAFF WILL RELY ON THIS INFORMATION FOR TREATING ME. 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 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/ LEGAL GUARDIAN_____

DATE_____