



Patient Health History and Acquaintance Form

PERSONAL INFORMATION

Patient Name _____ Nickname _____
Birthdate _____ SS# _____ Driver's License # _____
Marital Status: Married Single Widowed Divorced Separated Spouse or Guardian _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____
E-Mail Address _____
Referred By _____
Patient's Employer _____ Phone # _____
Emergency Contact _____ Phone # _____ Relationship to patient _____

DEPENDENT INFORMATION

Dependent's Name _____ M F Birthday _____
Dependent's Name _____ M F Birthday _____
Dependent's Name _____ M F Birthday _____
Dependent's Name _____ M F Birthday _____
Dependent's Name _____ M F Birthday _____

RESPONSIBLE PARTY

Name of person responsible for this account _____ Relationship to patient _____
Address _____ Home Phone _____
Birthdate _____ SS# _____ Driver's License # _____
Employer _____ Work Phone _____
Is this person currently a patient in our office? Yes No

INSURANCE INFORMATION

Name of insured _____ Relationship to patient _____
Birthdate _____ SS# _____ Date Employed _____
Name of Employer _____ Work Phone _____
Employer Address _____ City _____ State _____ Zip _____
Insurance Co. _____ Phone # _____
Group # _____ Subscriber ID # _____
Ins. Co. Address _____ City _____ State _____ Zip _____

SECONDARY INSURANCE INFORMATION

Name of insured _____ Relationship to patient _____
Birthdate _____ SS# _____ Date Employed _____
Employer address _____ City _____ State _____ Zip _____
Insurance Co. _____ Phone # _____
Group # _____ Subscriber ID # _____
Ins. Co. Address _____ City _____ State _____ Zip _____

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____

Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____

Are you taking any medications, pills, or drugs? Yes No If yes, please list: _____

Do you take or have you taken, Phen-Fen or Redux? Yes No

Have you ever taken Fosamax, Boniva, Actonel, or any medication containing a Bisphosphonate? Yes No

Are you on a special diet? Yes No

Do you use tobacco? Yes No If so, what type? _____

Do you use controlled substances? Yes No

Have you had any joint replacements? Yes No If yes, explain _____

Women: Are you...

Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain: _____

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

AIDS/HIV Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cortisone Medicine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Renal Dialysis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alzheimer's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis A	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anaphylaxis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Drug Addiction	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis B or C	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Easily Winded	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shingles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis/Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy or Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hives or Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypoglycemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joint	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Thirst	<input type="checkbox"/> Yes <input type="checkbox"/> No	Irregular Heartbeat	<input type="checkbox"/> Yes <input type="checkbox"/> No	Spina Bifida	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint Replacement	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach/Intestinal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Spells/Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Leukemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling of Limbs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breathing Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bruise Easily	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Genital Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors or Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pains	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain in Jaw Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cold Sores/Fever Blisters	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Attack/Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parathyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Yellow Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No
Convulsions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No		
		Heart Trouble/Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Weight Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Have you ever had any serious illness not listed above? Yes No If yes, please explain _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN _____ DATE _____