HEALTH HISTORY

Name (First, Middle, Last) _____ Title _____
Preferred Name _____ Email Address _____
Address _____ City _____ State _____ Zip _____
SS# _____ DOB _____ Marital Status_____
Home # _____ Cell # _____ Work # _____
Employer _____
Employer Address _____ City _____ State _____ Zip _____
Where and When is the best time to reach you? _____
Physicians Name _____ Phone # _____

Any changes to your health in the past five years?	Y N
Have you taken any medications or drugs in the past five years?	Y N
Have you taken any medications for Osteoporosis?	Y N
Are you pregnant or nursing?	Y N
Are you taking birth control pills or hormones?	Y N
Have you ever been denied permission to give blood?	Y N
Are you addicted or recovering from any Drug or Alcohol use?	Y N
Have you been under a care of a Physician in the past five years?	Y N

LIst Medications: _____

List all allergies: _____

Circle which applies:

Heart Trouble / Pacemaker	Kidney / Bladder Problem	Thyroid Problem	Bleeding Trouble / Ulcers
Heart Murmur / Mitral Valve Prolapse	Tuberculosis / Asthma / Lung Disease	Sexually Transmitted Disease	Hepatitis A, B, C, or Liver Disease
High Blood Pressure	Diabetes	Tumors / Cancers	Artificial Joints / Implants
Stroke	Epilepsy / Seizures	Smoking	Psychiatric Treatment

Sleep Apnea Evaluation

Have you ever been diagnosed with Sleep Apnea?	Y N
Have you ever had an overnight sleep study?	Y N
Do you wake up in the morning with headaches?	Y N
Have you been told that you gasp for air or suddenly stop breathing while sleeping?	Y N
Do you snore?	Y N
Do you or have you used a CPAP?	Y N

DENTAL HISTORY

What is your main concern for coming in?_____
Date of your last Dental Exam? _____
Reason for leaving your former Dentist? _____
What is your reaction to Dental treatment? Dread it / Worry about it / Do not mind it

Circle which applies:

Teeth Sensitivity	**Frequent Dry Mouth**	**Grinding / Clenching**	**Bleeding Gums**
Bad Breath / Taste	**Fever Blisters / Cold Sores**	**Crowded Teeth**	**Unhappy with Smile**

Primary Dental Insurance Coverage

Subscriber Name _____ **Relationship with Patient** _____
Address _____ **City/State** _____ **Zip** _____
Employer _____ **SS#** _____
Address _____ **DOB** _____
Insurance Co _____ **Plan Name**_____ **Group #** _____
Insurance Co. Address _____

Secondary Dental Insurance Coverage

Subscriber Name _____ **Relationship with Patient** _____
Address _____ **City/State** _____ **Zip** _____
Employer _____ **SS#** _____
Address _____ **DOB** _____
Insurance Co _____ **Plan Name**_____ **Group #** _____
Insurance Co. Address _____

Medical Insurance Coverage

Subscriber Name _____ **Relationship with Patient** _____
Address _____ **City/State** _____ **Zip** _____
Employer _____ **SS#** _____
Address _____ **DOB** _____
Insurance Co _____ **Plan Name**_____ **Group #** _____
Insurance Co. Address _____

Whom may we thank for your referral? _____

I certify that the above information is true and understand it will be held in the strictest of confidence.

Signature_____ **Date** _____