Health History From

Welcome! We are honored that you have chosen us to provide your dental care. If you have any questions at all, please don't hesitate to ask. So that we may provide the highest quality treatment available, we ask that you complete this form.

We assure you that the information will be held in the strictest confidence.

Name_____Name you prefer to be called_____

Date of Birth __/__/__ Social Security # _____

Address _____

City_____State_____Zip Code_____

Are you employed? __ Yes __ No If yes, where? _____
Home phone number (____)_____Work phone number(____)_____
Email Address _____Cell Phone number (____)_____
Emergency contact person _____
Relationship _____Phone number(____)_____
Are you covered under a dental insurance plan? __Yes __No
Have you been under the care of a physician recently? __Yes __No
Currently or recently, have you taken any drugs or medications? __Yes __No
If so, please list:_____
Do you have any allergies to any drugs or medications? __Yes __No
If so, please list:_____
Please indicate if you currently have or have ever had any of the following:

Asthma	__Yes __No	Dizzy spells/seizure	__Yes __No
Shortness of Breath	__Yes __No	Hepatitis	__Yes __No
Jaundice	__Yes __No	High Blood Pressure	__Yes __No
Rheumatic Fever	__Yes __No	Diabetes	__Yes __No
Heart Murmur	__Yes __No	HIV	__Yes __No
Mitral Valve Prolapse	__Yes__No	Stroke	__Yes __No
Chest Pain	__Yes __No	Artificial Joint	__Yes __No

Do you have any history of alcoholism, drug use? __Yes __No
Do you have any other condition, disease or problem that should be known? __Yes __No
If so, please explain:_____
Who is your present Medical doctor? _____
Who may we thank for referring you to our office?_____

Signature _____ Date_____