

HEALTH HISTORY

PATIENT'S NAME _____

TODAY'S DATE _____

Answer all questions by circling Yes (Y) or No (N)

All responses are kept confidential

1. Are you in good health?Y N
2. Has there been any change in your general health in the past year?Y N
3. Date of last physical exam _____
4. Are you now under a physician's care for a particular problem?Y N
5. Have you **ever** had any serious illnesses, operations or hospitalizations? If so, describe:Y N

- F. Tranquilizers?Y N
- G. Insulin or Oral Anti-Diabetic drugs?Y N
- H. Digitalis, Inderal, Nitroglycerin or other heart drug?.....Y N
- I. Please list any and all medications taken, including prescription medications, over-the-counter medications, herbal or holistic remedies, vitamins or minerals: _____

7. **DO YOU HAVE OR HAVE YOU EVER HAD:**

- A. Rheumatic Fever or Rheumatic Heart Disease?Y N
- B. Congenital Heart Disease?Y N
- C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?)Y N
- D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)?Y N
- E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness.....Y N
- F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily?Y N
- G. Liver Disease (Jaundice, Hepatitis)?.....Y N
- H. Kidney Disease?Y N
- I. Diabetes?.....Y N
- J. Thyroid Disease (Goiter)?.....Y N
- K. Arthritis?.....Y N
- L. Stomach Ulcers or Colitis?.....Y N
- M. Glaucoma?.....Y N
- N. Implants placed in your body (Heart Valve, Pacemaker, Hip, Knee)?Y N
- O. Radiation (X-ray) treatment for Cancer?Y N
- P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth?Y N
- Q. Sinus or Nasal problems?Y N
- R. Any disease, drug or transplant operation that has depressed your immune system?.....Y N

8. **ARE YOU USING ANY OF THE FOLLOWING:**

- A. Antibiotics?.....Y N
- B. Anticoagulants (Blood Thinners)?Y N
- C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen?.Y N
- D. High Blood Pressure medications?Y N
- E. Steroids (Cortisone, etc.)?Y N

9. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**

- A. Local Anesthesia (Novocain, etc.)?Y N
- B. Penicillin or other antibiotics?Y N
- C. Sedatives, Barbiturates?Y N
- D. Aspirin or Ibuprofen?.....Y N
- E. Codeine or other pain killers?Y N
- F. Latex or Rubber Products?Y N
- G. Other allergies or reactions? Please, list.....Y N

10. Do you smoke or chew Tobacco?Y N
How much per day? _____
11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you?Y N
12. Have you had any serious problems associated with any previous dental treatment?Y N
13. Do you have any other disease, condition or problem not listed above that you think the doctor should know about?Y N
14. Do you wish to talk to the doctor privately about anything?Y N

15. **FOR WOMEN ONLY**

- A. Are you Pregnant, or **is there any chance** you might be Pregnant?.....Y N
- B. Are you nursing?.....Y N
- C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I AFFIRM THAT THE INFORMATION GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE. IT WILL BE HELD IN THE STRICTEST CONFIDENCE AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY MEDICAL STATUS.

DATE _____

SIGNATURE _____

PATIENT REGISTRATION

TODAY'S DATE _____

PATIENT _____
FIRST NAME MIDDLE INITIAL LAST NAME PREFERRED NAME

PHONE NUMBERS: HOME _____ CELL PHONE _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

EMAIL _____ SEX: ___ MALE ___ FEMALE

BIRTHDATE _____ **SS#** _____ MARITAL STATUS _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____

RELATIONSHIP TO PATIENT _____

RESPONSIBLE PARTY **SS#** _____ **BIRTHDATE** _____

EMPLOYER _____ EMPLOYER PHONE # _____

SPOUSE NAME _____ **BIRTHDATE** _____ **SS#** _____

SPOUSE EMPLOYER _____ EMPLOYER PHONE # _____

PRIMARY DENTAL INSURANCE COMPANY: _____

ID# _____ **GROUP#** _____

SECONDARY DENTAL INSURANCE COMPANY: _____

ID# _____ **GROUP#** _____

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED? _____ **PHONE#** _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

I ASSIGN DIRECTLY TO SOUTHLAND SMILES, LTD ALL INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND I AM RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED, FOR PAYING ANY CO-PAYMENT, DEDUCTIBLES AND ANY COLLECTION FEES INCURRED TO SECURE PAYMENT ON MY ACCOUNT. I HEREBY AUTHORIZE SOUTHLAND SMILES, LTD TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL MY INSURANCE SUBMISSIONS WHETHER MANUAL OR ELECTRONIC.

DATE

SIGNATURE