

Patient Health History Forms

Patient Information

Email: _____ Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

How long at this address? _____

Home Phone: _____ Birthdate: (MM/DD/YYYY) _____

Social Security Number: _____

If patient is a minor, give parent's or guardian's name: _____

Employer: _____ Work Phone: _____

Occupation: _____ Years/ Months of Employment: _____

Spouse Name: _____ Spouse Birthdate: (MM/DD/YYYY) _____

Spouse Social Security Number: _____

Spouse Employer: _____

Spouse Occupation: _____ Years/ Months of Employment: _____

How did you learn about our office: _____

If you were referred by someone, whom may we thank? _____

Responsible Party/ Billing Information

Is the patient responsible for financial matters? If not, please fill out the following information for the responsible party.

Responsible Party Name: _____

Address: _____

City: _____ State: _____ Zip: _____

How long at this address? _____

Home Phone: _____ Work Phone: _____

Social Security Number: _____ Birthdate: (MM/DD/YYYY) _____

Relationship to patient: _____

Employer: _____

Occupation: _____ Years/ Months of Employment: _____

Spouse Name: _____ Spouse Birthdate: (MM/DD/YYYY) _____

Spouse Social Security Number: _____

Spouse Employer: _____

Spouse Occupation: _____ Years/ Months of Employment: _____

Insurance Information

Insured's Name: _____ Birthdate: (MM/DD/YYYY) _____

Social Security Number: _____ Insurance Company: _____

Group Number: _____ Insurance Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Do you have dual coverage? YES NO

Insured's Name: _____ Birthdate: (MM/DD/YYYY) _____

Social Security Number: _____ Insurance Company: _____

Group Number: _____ Insurance Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Medical History

Who is your primary care physician? _____

Physician's Phone: _____

How would you describe your overall health?

- Excellent
- Good
- Average
- Fair
- Poor

When was your last physical?

- Less than 3 months
- 3 months - 6 months
- 6 months - 1 year
- 1 year - 2 years
- 2 years - 5 years
- Over 5 years

Have you been hospitalized under a physician's care in the last two years? YES NO

If so, why? _____

Please list all medications/drugs you are taking: _____

Have you ever had an adverse reaction or allergies to any medication or substance?

(Please check if allergic.)

- | | | |
|-------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Iodine | <input type="checkbox"/> Nitrous Oxide |
| <input type="checkbox"/> Novocaine | <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Valium |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Xylocaine |

Others: _____

Have you ever had any of the following? (Please check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Arthritis or Gout | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Heart Trouble |
| <input type="checkbox"/> Asthma or Allergies | <input type="checkbox"/> Heart Valve or Pacemaker |
| <input type="checkbox"/> Bleeding Problem or Anemia | <input type="checkbox"/> Hepatitis (A) |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Hepatitis (B) |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Hepatitis (C) |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High/Low Blood Pressure |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Hypoglycemia |

- Congenital Heart Problems
- Currently Pregnant
- Diabetes
- Dizziness or Fainting
- Drug/Alcohol Addiction
- Eating Disorder
- Emphysema
- Epilepsy or Seizures
- Fever Blisters
- Frequent Thirst
- Frequent Urination
- Glaucoma
- HIV-AIDS-ARC
- Heart Attack or Stroke

- Jaw Joint Pain
- Kidney or Liver Disease
- Lung Disease
- Psychiatric Care
- Radiation/Chemotherapy
- Rheumatic Fever
- Sinus Problems
- Thyroid Problems
- Tuberculosis
- Tumor or Growth
- Ulcers or G.I. Problems
- Use Tobacco
- X-ray/Chemotherapy

Do you have any condition or problem not listed about which we should know about? Please explain:

Have you ever been given antibiotics before dental treatment? YES NO

Have you recently consumed alcohol? YES NO

Have you recently used recreational drugs? YES NO

Dental History

What are your present dental concerns? _____

When was your last dental visit?

- Less than 3 months
- 3 months - 6 months
- 6 months - 1 year
- 1 year - 2 years
- 2 years - 5 years
- Over 5 years

When was your last cleaning?

- Less than 3 months
- 3 months - 6 months
- 6 months - 1 year
- 1 year - 2 years
- 2 years - 5 years
- Over 5 years

Have you avoided regular dental care? YES NO

Why? _____

Do you feel you have active decay? YES NO

Do you experience frequent bad breath? YES NO

Do you feel you have gum disease? YES NO

Have you ever had gum treatments? YES NO

How often do you brush?

- Less than once a week
- Once weekly
- Several times weekly
- Once a day
- Twice a day
- Three times a day

When were your last dental x-rays?

- Less than 3 months
- 3 months - 6 months
- 6 months - 1 year
- 1 year - 2 years
- 2 years - 5 years
- Over 5 years

Floss?

- Less than once a week
- Once weekly
- Several times weekly
- Once a day
- Twice a day
- Three times a day

Use other aids?

- Less than once a week
- Once weekly
- Several times weekly
- Once a day
- Twice a day
- Three times a day

Are you happy with the appearance of your teeth? YES NO

Would you like your teeth to be whiter? YES NO

What are your dental expectations? _____

Name of previous dentist: _____

City: _____ State: _____

Shall we request your records from your previous dentist? YES NO

How would you rate your previous dental experience?

- Excellent
- Good
- Average
- Fair
- Poor

Nearest Relative

Name of nearest relative not living with you?

Address _____

City: _____ State: _____

Zip: _____

Assignment and Release

I, the undersigned, certify that I (or my dependant) have insurance coverage with, (Name of Insurance Company) _____ and assign directly to Metrowest Family Dental all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I hereby authorize the doctor to release all information necessary to secure the payment benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party

Relationship

Date

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____