HOLEHOUSE CENTER FOR COMPLETE DENTISTRY HEALTH HISTORY FORM

Date _____

Name _____ First Name Preference _____

Address _____ City _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth _____ Social Security #_____

Minor___ Single___ Married___ Divorced___ Separated___ Other___

Email _____ Occupation _____

In case of emergency, please contact: Name & Phone _____

Whom may we thank for referring you to our office? _____

Dental Insurance Information

Who is responsible for this account? _____ Relationship to Patient _____

Birth date of policy owner _____ Their Social Security # _____

Insurance Co._____ Phone # _____

Assignment & Release: I certify that I and/or my dependant(s) have insurance coverage with and assign directly to Dr. Holehouse 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 authorize the use of my signature on all insurance submissions.

_____ _____

Signature of Patient Date

Dental History

Why have you come to see us today? _____

Do you have specific area(s) causing you discomfort? _____

Have you had any sores/bumps in or near your mouth? _____ If yes, how often/where? _____

Are your teeth sensitive to Heat, Cold, Sweets, Biting Pressure? _____ Where? _____

Is your bite comfortable when biting/chewing? _____ Do you feel that you grind your teeth? _____

Does your jaw hurt/feel tired? _____

When was the last time you saw a dentist? _____ Name of previous dentist? _____

How often do you brush? _____ Floss? _____ Do your gums ever bleed? _____

If you could easily and safely whiten your teeth, would you be interested? _____

Do you have any old fillings or dental treatment that you are unhappy with? _____

Do you currently wear a dental appliance? _____

Health History

Are you under a Physician's care now? __Yes __ No If yes, nature of care: _____

_____

Have you been hospitalized in the past 5 years? __Yes __No If yes, reason _____

_____

Have you ever had a serious head or neck injury? _____ If so, explain _____

Are you currently taking any OTC supplements or Rx medications? Purpose? Please list _____

_____

_____

Have you <u>ever</u> taken **Phen-fen/Redux**? __Yes __No If Yes Please explain: _____

Have you <u>ever</u> taken **Fosamax, Boniva or Actonel**? Or other bisphosphonates, taken through an IV, such as **Aredia** or **Zometa**? ___Yes ___ No If Yes, For what condition, for how long, and when was your last dose?

_____

Do you use Tobacco products? __Yes __No If yes, what type and how much: _____

<u>For Women only:</u> Are you pregnant or planning to become pregnant? __Yes __No If yes, due date: _____

Are you nursing? __Yes __No Are you taking oral contraceptives? __Yes __No

Do you premedicate w/ antibiotic for dental treatments? __Yes __No If yes, why? _____

Are You <u>Allergic</u> to or Have You Had an <u>Adverse Reaction</u> to:

Y N Aspirin Y N Penicillin Y N Codeine Y N Acrylic

Y N Metal Y N Latex Products Y N Sulfa Drugs Y N Local Anesthetics

Y N Other _____

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

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

Y N Other serious illness not listed above, Explain _____

Please list all names and phone numbers of the physicians who are currently providing you care:

1. _____
2. _____
3. _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or exam rendered to me or my child during the period of such Dental care to third party payers and/ health practitioners. If my health or medications change, I will inform my doctor at my next appointment.

_____ _____ _____

Signature of Patient Date Signature of Doctor Date