Health History Form – Adult

Patient Information

Patient's Name:_____ Age: _____ Birth date: _____

Home Phone#: _____ Cell Phone#:_____ Email: _____

Address:_____ City: _____ State:_____ Zip: _____

Social Security #:_____ Employer: _____Occupation:_____

Time at current residence: _____ Time at current employer: _____ Marital Status: _____

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

Spouse/Additional Contact Information

Name: _____ Home Phone#: _____ Cell Phone#:_____

Address:_____ City: _____ State:_____ Zip: _____

Time at this residence: _____ Social Security #: _____ Birth Date: _____

Relationship to Patient: _____ Employer: _____ Occupation:_____

No. of years employed: _____

Dental Insurance Information Please provide all information in order to accurately verify insurance benefits

Insured's Name: _____ Insured's SS#: _____ Insured's DOB:_____

Insurance Member ID:_____ Group#:_____Insurance Co: _____

Insurance Co. Address: _____

Phone: _____ Insured's Employer: _____

Do you have dual coverage? ☐Yes ☐No If yes,

Insured's Name: _____ Insured's SS#: _____ Insured's DOB:_____

Insurance Member ID:_____ Group#:_____Insurance Co: _____

Insurance Co. Address: _____

Phone: _____ Insured's Employer: _____

Medical/Dental History

Physician's Name: _____ Phone: _____

Dentist's Name: _____ Phone: _____

☐Yes ☐No Are you currently under any medical treatment? If so, what kind?_____

☐Yes ☐No Do you have pain, clicking, and/or popping noises in the jaw?

☐Yes ☐No Are you aware of either clenching or grinding of teeth? History of night guard? ☐ Yes ☐ No

☐Yes ☐No Do you have frequent headaches? How often? _____

☐Yes ☐No Do you have ear problems? (aches, ringing, dizziness, fullness)

☐Yes ☐No Do you have difficulty breathing through the nose?

☐Yes ☐No Do you have habits such as nail biting, finger or thumb sucking, lip or cheek biting?

☐Yes ☐No Do you have speech problems, or are you in speech therapy?

☐Yes ☐No Have you had your tonsils and/or adenoids removed?

Has there been any history of: ☐ Joint swelling ☐ TB ☐ Aids ☐ HIV ☐ Asthma

☐ Kidney ☐ Liver Condition ☐ Epilepsy ☐ Rheumatic fever

☐ Other major illnesses? _____

☐Yes ☐No Do you bleed easily? Anemic: ☐ yes ☐ no

☐Yes ☐No Is there a tendency to faint or become dizzy?

☐Yes ☐No Do you have allergies? (LATEX, sulphur, penicillin, novocaine, etc.) _____

☐Yes ☐No Are you currently taking any medication? List: _____

☐Yes ☐No Has there been a history of growth hormone therapy? If so when and how long? _____

☐Yes ☐No Do you have a heart condition? Cardiologist:_____

☐Yes ☐No Does the patient pre-medicate?

☐Yes ☐No Are you currently pregnant? If yes, what is the due date: _____

☐Yes ☐No Do you have a history of calcium replacement therapy?(Flosamax or Boniva) if yes, how long?____

☐Yes ☐No Have you been diagnosed with sleep apnea? If so do you use CPAP machine? ☐ Yes ☐ No

☐Yes ☐No Do you smoke or chew tobacco? Quantify Usage: _____

☐Yes ☐No History of facial trauma or injuries to the teeth? Explain: _____

☐Yes ☐No Have you had any permanent teeth, other than wisdom teeth, extracted?

☐Yes ☐No Have we treated any other family members? Who: _____

Any other medical concerns not listed above: _____

Signature: _____Date:_____