Original Date:
Dates Revised:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your dental record.

Patient name: ☐ M ☐ F		**SSN:**
Street address:		**DOB:**
City:	**State:**	**Zip:**
Email address:		
Cell phone:	**Home phone:**	
Do you consent to receive text messages? ☐ Yes ☐ No	**Work phone:**	
Marital status: ☐ Minor ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Spouse or parent/guardian's name:		
How did you hear about us?		
Emergency contact:	**Phone:**	

RESPONSIBLE PARTY

***If person responsible is the same as the patient, please skip to Dental Insurance Information and check this box** ☐

Name of person responsible for account:		**Relationship:**
Street address:		**POA:** ☐ Yes ☐ No
City:	**State:**	**Zip:**
Email address:		
DOB:	**Home phone:**	**Cell phone:**
Is this person currently a patient in our office? ☐ Yes ☐ No		**Work phone:**

DENTAL INSURANCE INFORMATION

Name of insured:		**Relationship:**
DOB:	**SSN:**	**Employer phone:**
Employer:		
Street address of employer:		
City:	**State:**	**Zip:**
Insurance company:	**ID#**	**Group#**
Insurance company address:		
City:	**State:**	**Zip:**

Do you have additional dental insurance? ☐ Yes ☐ No **If yes, please complete the following:**

Name of insured:		**Relationship:**
DOB:	**SSN:**	**Employer phone:**
Employer:		
Street address of employer:		
City:	**State:**	**Zip:**
Insurance company:	**ID#**	**Group#**
Insurance company address:		
City:	**State:**	**Zip:**

MEDICAL HISTORY

Physician's name:	Physician's phone:
Are you under medical treatment now? ☐ Yes ☐ No	If yes, explain:
Have you ever been hospitalized for a surgical operation or illness within the past 5 years? ☐ Yes ☐ No	If yes, explain:
Are you taking any medications? ☐ Yes ☐ No	If yes, please list:

Have you taken any cancer/osteoporosis medication containing bisphosphonates? ☐ Yes ☐ No

Have you ever taken Fen-Phen or Reux? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No	Do you use smokeless tobacco? ☐ Yes ☐ No
Do you use controlled substances? ☐ Yes ☐ No	Are you wearing contact lenses? ☐ Yes ☐ No

Are you allergic or have you had any reactions to the following?

Local anesthetics ☐ Yes	Sedatives ☐ Yes
Penicillin ☐ Yes	Iodine ☐ Yes
Sulfa drugs ☐ Yes	Aspirin ☐ Yes
Other antibiotics ☐ Yes	Any metals (nickel, mercury, etc.) ☐ Yes
Barbituates ☐ Yes	Latex Rubber ☐ Yes
Any other allergies? ☐ Yes ☐ No	If yes, please list:

Do you have a persistent cough or throat clearing not associated with an illness lasting more than 3 weeks? ☐ Yes ☐ No

Women only:	
	Are you taking oral contraceptives? ☐ Yes ☐ No
	Are you nursing? ☐ Yes ☐ No
	Are you pregnant or think you may be pregnant? ☐ Yes ☐ No

Please check any medical issues you have or have had in the past.

High blood pressure ☐ Yes	Heart disease ☐ Yes	Chest pains ☐ Yes
Heart attack ☐ Yes	Cardiac pacemaker ☐ Yes	Easily winded ☐ Yes
Rheumatic fever ☐ Yes	Heart murmur ☐ Yes	Stroke ☐ Yes
Swollen ankles ☐ Yes	Angina ☐ Yes	Hay fever/allergies ☐ Yes
Seizures/fainting ☐ Yes	Frequently tired ☐ Yes	Tuberculosis ☐ Yes
Asthma ☐ Yes	Anemia ☐ Yes	Radiation therapy ☐ Yes
Low blood pressure ☐ Yes	Emphysema ☐ Yes	Glaucoma ☐ Yes
Epilepsy/convulsions ☐ Yes	Cancer ☐ Yes	Recent weight loss/gain ☐ Yes
Leukemia ☐ Yes	Arthritis ☐ Yes	Liver disease ☐ Yes
Diabetes ☐ Yes	Joint replacement/implant ☐ Yes	Heart trouble ☐ Yes
Kidney disease ☐ Yes	Hepatitis/jaundice ☐ Yes	High cholesterol ☐ Yes
AIDS or HIV infection ☐ Yes	Sexually transmitted disease ☐ Yes	Respiratory problems ☐ Yes
Thyroid problem ☐ Yes	Stomach troubles, ulcers ☐ Yes	Mitral valve prolapse ☐ Yes
Acid reflux ☐ Yes	Osteoporosis ☐ Yes	

Please list any other conditions not listed or explain the above if needed:

DENTAL HISTORY

Name of previous dentist:	Last dental exam:
Do your gums bleed when brushing or flossing? ☐ Yes	Do you have frequent headaches? ☐ Yes
Are your teeth sensitive to hold/cold/sweets? ☐ Yes	Do you clench or grind your teeth? ☐ Yes
Do you feel pain in any of your teeth? ☐ Yes	Do you bite your lips or cheeks frequently? ☐ Yes
Do you have any lumps or sores in or near your mouth? ☐ Yes	Have you had difficult extractions in the past? ☐ Yes
Have you had any head, neck, or jaw injuries? ☐ Yes	Have you ever had prolonged bleeding? ☐ Yes
Have you experienced clicking in the jaw? ☐ Yes	Have you had orthodontic treatment? ☐ Yes
Have you experienced pain in the joint, ear, or side of face? ☐ Yes	Do you wear dentures, partials, or a retainer? ☐ Yes
Do you have difficulty opening, closing, or chewing? ☐ Yes	Do you like your smile? ☐ Yes ☐ No

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 examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual billed services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X____

Signature of patient (or parent/guardian if minor) **Print name** **Date**