HEARTFELT
HEADACHE RELIEF

(844) 794-4323
114 W. Neider Avenue, Suite 103
Coeur d'Alene, ID 83815

PLEASE FILL OUT THIS FORM COMPLETELY SO THAT WE MAY BETTER CARE FOR YOU.

ABOUT YOU

Today's date:

Name:

Mr Mrs Ms Dr | First | MI | Last

I prefer to be called:

Birthdate: | Age: | SS#:

Home Address: | Apt/Condo#

City: | State: | Zip:

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home Phone: | Cell Phone:

Work Phone: | Ext#: | Fax:

Email Address:

Employer: | Employer's Address:

How long there? | Occupation:

Who may we thank for referring you? | Other family members seen by us?

Who will pay this Account? | Signature:

If using Credit Card: Name: | Card Number:

Signature: | Exp. Date:

By signing above, I authorize any unpaid balance on my account to be charged to my credit card above.

SPOUSE INFORMATION

Name:

First | MI | Last

Employer:

Work Phone: | Ext#: | Cell#:

Birthdate: | SS#:

EMERGENCY INFORMATION

In the event of an emergency, is there someone who lives near you that we should contact?

Name: | Relation:

Home Phone: | Cell Phone:

Work Phone: | Ext#:

DENTAL HISTORY

Why have you come to the dentist?

Are you currently in pain? ☐ No ☐ Yes

Have you ever had a serious | difficult problem associated with any previous dental work? ☐ No ☐ Yes

Do you now or have you ever experienced pain | discomfort in your jaw joint? (TMJ | TMD)? ☐ No ☐ Yes

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ No ☐ Yes

Why or why not?

Do your gums ever bleed? ☐ No ☐ Yes

# of times a week you floss? _____ # of times a day do you brush? _____

Type of bristles: ☐ Hard ☐ Medium ☐ Soft

Previous | Present Dentist (please circle)

Last Visit Date:

Last Cleaning Date:

Last X-Rays:

MEDICAL HISTORY

Physician's Name: | Phone #:

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ No ☐ Yes

Please explain:

Are you taking any prescription | over the counter drugs? ☐ No ☐ Yes

Please list any medications:

Are you currently taking any bone density medication? ☐ No ☐ Yes

Please list any medications:

Do you smoke or use tobacco in any form? ☐ No ☐ Yes

Have you ever been hospitalized? ☐ No ☐ Yes

If so, for what?

Do you need antibiotic premedication for rheumatic fever, heart murmur or artificial prosthesis, before dental treatment? ☐ No ☐ Yes

For women, are you taking birth control pills? ☐ No ☐ Yes

Are you pregnant? Week#: _____ ☐ No ☐ Yes

Are you nursing? ☐ No ☐ Yes

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Have you ever had any of the following diseases or medical problems? Circle yes or no.

Y	N	Heart Attack | Stroke	Y	N	High | Low Blood Pressure	Y	N	Sleep Apnea (w/ use of CPAP)
Y	N	Cancer | Chemotherapy	Y	N	Fever Blisters	Y	N	Sleep Apnea (w/o use of CPAP)
Y	N	Heart Murmur	Y	N	Severe | Frequent Headaches	Y	N	Congenital Heart Defect
Y	N	Rheumatic Fever	Y	N	Severe | Frequent Migraines	Y	N	Anemia
Y	N	HIV+ | AIDS	Y	N	Pyschiatric Problems	Y	N	Head or Neck Pain
Y	N	Heart Surgery | Pacemaker	Y	N	Epilepsy | Seizures | Fainting	Y	N	Radiation Treatment
Y	N	Shingles	Y	N	Diabetes	Y	N	Asthma
Y	N	Mitral Valve Prolapse	Y	N	Tuberculosis	Y	N	Arthritis
Y	N	Kidney Problems	Y	N	Drug | Alcohol Abuse	Y	N	Difficulty Breathing
Y	N	Artificial Bones | Joints	Y	N	Venereal Disease	Y	N	Hepatitis
Y	N	Artificial Valves	Y	N	Hemophilia | Abnormal Bleeding	Y	N	Blood Transfusion
Y	N	Sinus Problems	Y	N	Ulcers | Colitis	Y	N	Emphysema
Y	N	TMJ / TMD Discomfort	Y	N	Facial Pain	Y	N	Glaucoma
			Y	N	Snoring	Y	N	Tinnitus (ringing in ears)

Please list any serious medical condition(s) that you have ever had:

Are you allergic to any of the following? Circle yes or no.

Y	N	Penicillin	Y	N	Erythromycin	Y	N	Latex
Y	N	Aspirin	Y	N	Codeine	Y	N	Other
Y	N	Tetracycline	Y	N	Dental Anesthetics			

Please list any other drugs that you are allergic to:

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

Signature: _____ Date: _____