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GENERAL COSMETICS IMPLANTS

Thank you for choosing our office. In order to serve you properly, please answer all questions on all pages, so that we may diagnose your oral health as accurately as possible. All information will be kept strictly confidential.

PATIENT'S NAME____________________ PREFERRED NAME________________

Social Security No.________________ Birthdate______________

Mailing Address____________________ Email ________________

City____________ State_____ Zip Code______ Home Phone No. ____________

Cell Phone No. ____________ How should we contact you? ❑Home ❑Cell ❑Work ❑Email ❑Text

❑Married ❑Single ❑Divorced ❑Separated ❑Widowed

Patient Occupation____________ Employer____________ Work Phone____________

Name of Spouse/Partner____________ Birthdate________ SSN____________

Spouse Occupation____________ Employer____________ Work Phone____________

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT? (Other than someone living with you)

Name____________ Home Ph. No. ____________ Work Ph. No. ____________

Relationship to patient ________________________

WHOM MAY WE THANK FOR REFERRING YOU TO US? ____________________

Insurance & Billing Information

Person responsible for payment: ________________________

Responsible persons address:____________________ Phone#____________

Primary Dental Insurance

Subscriber____________________

Subscriber ID#____________________

Subscriber D.O.B. ____________________

Subscriber Address____________________

Subscriber Phone #____________________

Relationship to Patient ____________________

Employer ____________________

Insurance Co.____________ Group# ______

Insurance Address____________________

Insurance Phone #____________________

Secondary Dental Insurance

Subscriber____________________

Subscriber ID#____________________

Subscriber D.O.B. ____________________

Subscriber Address____________________

Subscriber Phone #____________________

Relationship to Patient ____________________

Employer ____________________

Insurance Co.____________ Group# ______

Insurance Address____________________

Insurance Phone #____________________

CONSENT TO TREATMENT

I grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form, to administer upon explanation such anesthetics, analgesics, sedatives, nitrous oxide sedation; and to perfrom such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss matters related to this form.

Patient Name________________________ Date____________

MEDICAL HISTORY

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

Name of current physician or medical specialist City/State Phone ( )

____

List Medications/Herbal Supplements currently taking, dosage and condition _______________________________

____

____

Check any of the following conditions which you have now or have had in the past.

❑**No Medical Conditions**
❑A.I.D.S. or H.I.V.
❑Allergies or Hay Fever
❑Angina Pectoris (Chest Pain)
❑Arthritis or Rheumatoid or Osteo
❑Artificial Heart Valve
❑Artificial Joints (Hip, Knee, etc.)
❑Asthma
❑Auto Immune Disorder
❑Congenital Heart Defect
❑Diabetes, Type I ❑ II ❑
❑Emphysema or COPD
❑Epilepsy or Seizures
❑Heart Disease or Attack
❑Heart Murmur or Rheumatic Fever
❑Heart Pacemaker
❑Heart Surgery
❑Hepatitis: A, B, C
❑High Blood Pressure
❑Kidney Failure or Disease
❑Liver Disease
❑Mental Health Condition
❑Premed for dental appointments
❑Sinus Trouble
❑Sleep Apnea
❑Stroke
❑Thyroid Disease or Condition
❑Ulcers or Intestinal Disease
❑Other_______________

Are you allergic to or have you reacted adversely to any of the following? *(check all that apply)*

❑Aspirin ❑Codeine ❑Latex ❑Local Anesthetic ❑Penicillin ❑Other Antibiotics

*List any other allergies here:*____

Do you Smoke? .... ❑Yes ❑No Use Smokeless Tobacco? .... ❑Yes ❑No Use E-Cigarettes? .... ❑Yes ❑No

Are you currently being treated for cancer or have you been treated in the past for cancer? ❑Yes ❑No Type of treatment ______________

Are you or could you be pregnant? ....❑Yes ❑No Are you nursing? ....❑Yes ❑No Are you taking Birth Control pills? ... ❑Yes ❑No

Have you undergone Osteoporosis Therapy? (e.g.: Fosamax, Actonel, Boniva) .... ❑Yes ❑No

Are you now or have you ever been addicted to a chemical substance? (e.g.: Alcohol, Perscription Drugs, Heroin, Meth, Cocaine, Other) .... ❑Yes ❑No

How do you rate your sleep 1-10? _____________Do you snore? .... ❑Yes ❑No or Have you been told that you snore? .... ❑Yes ❑No

Do you have any disease, condition or concern not listed that you believe that we should know about? (please list)

____

DENTAL HISTORY (Please Print)

Purpose of Appointment ____

How long since your last dental treatment___________________ When was your last dental cleaning? ____________________

Name of previous Dentist City/State Phone ( )

____

Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike.................................... ❑Yes ❑No

Have you ever had any trouble or complications with previous dental treatment? .... ❑Yes ❑No

If yes, explain____

Have you ever been diagnosed with gum disease? ❑Yes ❑No .... Gum treatment or surgery? .... ❑Yes ❑No

Do you clench or grind your teeth? ❑Yes ❑No .... Do you wear a nightguard? .... ❑Yes ❑No

Have your teeth changed in the last 5 years? ❑Yes ❑No (check all that apply) If yes, ❑shorter ❑thinner ❑worn ❑cosmetic

Are any of your teeth sensitive? ❑Yes ❑No (check all that apply) If yes, ❑ hot ❑ cold ❑ sweets ❑ pressure

Do you experience frequent (check all that apply) ❑ headaches? ❑ neck aches? ❑ shoulder aches?

Muscle pain/soreness of your face or around your ear? ❑Yes ❑No

Do you have jaw or jaw joint problems? ❑Yes ❑No If yes, (check all that apply) ❑ pain ❑ sounds ❑ limited opening ❑ locking ❑ popping

Do you have more than one bite or do you need to clench (squeeze) to make your teeth fit together? .... ❑Yes ❑No

Do you have difficulty with chewing gum? ❑Yes ❑No Chewy or hard foods? ❑Yes ❑No Other ______________________________

How do you rate your smile 1-10? _______What would it take to get your smile there? ______________________________

Where do you want it to be 1-10? ________

I 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.

Update Record

Date	Initial
______	______
______	______
______	______

Patient Name____ **Date**________________________

AHH 18.09.17