New Patient Health History

Name: ______________________________ Phone #: (____)_____-______

Address:____
Street City State Zip Mobile #

Primary Care Physician: ______________________ Phone #: (____)_____-_____

Are you currently taking any medications, including regular doses of aspirin? YES NO

If so, please list name and dosage ______________________________

Are you aware of having an allergic reaction to any medication or substance? YES NO

If so, please list ______________________________

Have you been under the care of a medical doctor during the past two years? YES NO

If so, for what ______________________________

Have you seen an ear nose and throat doctor?	YES	NO	Name: __________
Have you seen a chiropractor?	YES	NO	Name: __________
Have you seen a neurologist?	YES	NO	Name: __________
Have you seen an orthodontist?	YES	NO	Name: __________
Do you take any pre-medication (antibiotics) for dental procedures?	YES	NO	
Did some one refer you to the office?	YES	NO	Name: __________
Have you ever had a whiplash injury?	YES	NO	When: __________

Indicate by circling either yes or no for each items in which you have presently or had in the past

Congenital Heart Failure	YES	NO	Jaw Pain	YES	NO
Heart Murmur	YES	NO	Jaw Popping	YES	NO
Mitral Valve Prolapse	YES	NO	Limited Opening	YES	NO
Artificial Heart Valve	YES	NO	Congested Ears	YES	NO
Pacemaker	YES	NO	Dizziness	YES	NO
Stroke	YES	NO	Ringing Ears	YES	NO
Artificial Joint(s)	YES	NO	Loose Teeth	YES	NO
Liver Disease/Jaundice	YES	NO	Postural Problems	YES	NO
Kidney Trouble	YES	NO	Clenching	YES	NO
Trigeminal Neuralgia	YES	NO	Grinding	YES	NO
HIV / AIDS	YES	NO	Facial Pain	YES	NO
Neurological Disorders	YES	NO	Sensitive Teeth	YES	NO
Radiation/Chemotherapy	YES	NO	Neck Ache	YES	NO
Psychiatric/Psychological	YES	NO	Headache	YES	NO
Asthma	YES	NO	Does floss shred when you use it?		
Epilepsy / Seizures	YES	NO		YES	NO
Latex Sensitivity	YES	NO	Does food pack or catch between your teeth?		
Hepatitis	YES	NO		YES	NO
Tingling arms/fingers	YES	NO	Do you smoke or chew tobacco?		
Sickle Cell Disease	YES	NO		YES	NO
Bell's palsy	YES	NO	Do your gums bleed?		
Difficulty Swallowing	YES	NO		YES	NO
Acid Reflux	YES	NO	Does your breath concern you?		
Diabetes	YES	NO		YES	NO
Insomnia/Frequent Waking	YES	NO	Do you feel sleepy during the day?		
High Blood Pressure	YES	NO		YES	NO

Do you use a CPAP/BiPAP machine or have performed a sleep study? YES NO

Have you ever been told you snore or stop breathing during sleep? YES NO

Do you have or had any disease, condition, syndrome, or problem no listed? ____________

Women: Are you: Pregnant _____ Nursing _____ Take birth control pills _____

(CONTINUED ON FOLLOWING PAGE)

Emergency Contact Information

Primary:__________ Phone # (____)_____-_____

Secondary:__________ Phone # (____)_____-_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider who may release such information to you. I will notify the doctor of any change in my health or medication.

Signature: ____ Date: _____/_____/_____
Patient or Legal Guardian

Social Security Number _____-_____-_____ Date of Birth: ____/_____/_____

Email Address: ___________________________________

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