

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 YES

Pacemaker YES NO NO

Stroke YES NO Dizziness YES NO

Artificial Joint(s) YES NO Ringing Ears YES NO

Liver Disease/Jaundice YES NO Loose Teeth YES NO

NO NO Postural Problems YES NO

Kidney Trouble YES NO Clenching YES NO

NO NO Grinding YES NO

Trigeminal Neuralgia YES NO Facial Pain YES NO

HIV / AIDS YES NO Sensitive Teeth YES NO

Neurological Disorders YES NO Neck Ache YES NO

NO NO Headache YES NO

Radiation/Chemotherapy YES NO Does floss shred when you use it? YES NO

Psychiatric/Psychological YES NO YES NO

Asthma YES NO Does food pack or catch between your teeth? YES NO

Epilepsy / Seizures YES NO YES NO

Latex Sensitivity YES NO Do you smoke or chew tobacco? YES YES

Hepatitis YES NO NO

Tingling arms/fingers YES NO Do your gums bleed? YES NO

Sickle Cell Disease YES NO YES NO

Bell's palsy YES NO Does your breath concern you? YES YES

Difficulty Swallowing YES NO NO

Acid Reflux YES NO Do you feel sleepy during the day? YES NO

Diabetes YES NO YES NO

Insomnia/Frequent Waking YES NO YES NO

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)

Primary: Phone # (____) ____ - ____

Secondary: Phone # (____) ____ - ____

Emergency Contact Information

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: _____
Patient or Legal Guardian

Date: ____/____/____

Social Security Number ____-____-____

Date of Birth: ____/____/____

Email Address: _____



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