# CONFIDENTIAL HEALTH HISTORY

Date _____

PATIENTS NAME MISS. MRS. MR.DR._____ BIRTH DATE_____
IF A MINOR OR DEPENDENT
PARENTS OR GUARDIANS NAME_____MARITAL STATUS_____

RESIDENCE ADDRESS_____ ZIP_____ HOME #. _____

SOCIAL SECURITY NUMBER_____ WORK #._____ CELL #._____

PERSONAL PHYSICIAN_____PHONE NO._____

WHO WILL PAY THIS PROFESSIONAL FEE?_____ADDRESS_____

EMAIL _____PREFERRED CONTACT METHOD _____

DO YOU HAVE DENTAL INSURANCE THAT MAY COVER A PORTION OF THIS FEE YES ___ NO____ DON'T KNOW ____

NAME OF COMPANY_____GROUP OR POLICY # _____

PLEASE X ANY OF THE FOLLOWING CONDITIONS THAT CURRENTLY OR IN THE PAST APPLY TO YOU. IF OTHER EXPLAIN ON BACK .

**EYES/EARS/NOSE/ THROAT**
__ Glaucoma
__ Loss of Vision
__ Sinus Infections
__ Loss of Hearing
__ Ringing In Ears
__ Difficulty Swallowing
__ Lumps
__Surgery
__Sleep Apnea
__Snoring
__Other

**Mouth**
__Broken Jaw
__Clicking/Popping Jaw
__Difficulty Closing Jaw
__Unpleasant Taste
__Bleeding Gums
__Sore Gums
__Fever Blisters
__Biting Lips/Cheeks
__Smoke/Chew Tobacco
__Dry Mouth
__Other

**Teeth**
__Braces/Orthodontics
__Tartar/Calculus
__Loose Teeth
__Sensitive to Hot
__Sensitive to Cold
__Sensitive to Sweets
__Wedging of Food
__Grinding
__Other

**HEART**
__**Heart Murmur**
__**Mitral Valve Prolaps**
__**Pacemaker**
__**Artificial Heart Valves**
__Rheumatic Fever
__Heart Attack
__Angina
__Surgery
__Chest Pain
___Irregular Breathing
___Swollen Feet/Ankles
___High Cholesterol
___High Blood Pressure
___ Low Blood Pressure
___Congenital Heart Defect
___Congestive Heart Failure
___Other

**Blood**
__Hemophilia
__Sickle Cell Anemia
__Pernicious Anemia
__Biopsy Bone Marrow
__Lymph Node Problem
__AIDS/HIV
__**Dialysis**

**Respiratory**
__ Tuberculosis
__Asthma
__Persistent Cough
__Irregular Breathing
__Cough up Blood
__Cystic Fibrosis
__Smoke
__Packs per day
__How many years
__COPD
__Other

**NERVOUS SYSTEM**
__ Seizure
__ Stroke
__ Paralysis
__ Tingling
__ Headaches/Migraines
__ Numbness
__ Loss of Speech
__ Loss of Consciousness
__ Memory Loss
__ Depression
__ Psychiatric Problems
__ Epilepsy
__ Other

**Stomach/Liver/Intestines**
__ Hepatitis
__ Enlarged Liver
__ Vomiting
__ Hernia
__ Ulcers
__ Loss of Appetite
__ Polyps
__ Surgery
__ Other

**Endocrine**
__ Diabetes
__ Frequent Urination
__ Thirstiness
__ Thyroid Problems
__ Autoimmune Disorder
__ Other

**Urinary**
__ Kidney Infection
__ Bladder Infection
__ Venereal Disease
__ Bloody Urine
__ Painful Urination
__ Frequent Urination
__ Other

**ALLERGY**
__ **Any Dental Anesthetics**
__ Erythromycin
__ Penicillin
__Any other antibiotics
__ **Tree Nuts**
__ Codeine
__ Aspirin
__ Sulfa Drugs
__ Any other medications
__ Any Jewelry/Metals
__ Latex
__ Other

**Bones/Muscles/Joints**
___Breaks
___Stiffness
___Arthritis
___Gout
___Osteoporosis
___**Prosthetic joint**
___Other

**OB/GYN (Women only)**
__ Birth Control Pills
__ Surgery
__ Are you pregnant?
__ Due Date
__ Nursing
__ Other

**Misc./Other**
__ Cancer
__ Chemotherapy
__ Radiation Therapy
__ Head/Neck radiation
__ Tumors
__ Skin Lesions
__Drug /Alcohol Abuse
__ Osteoporosis medications
__**Bisphosphonate therapy**

Please explain "OTHER" for any condition on the reverse side. May we check with your physician concerning your health records ? Yes/No
Please explain on the reverse side of this page any health problem(s) you have had that you feel we should be aware of.

Physician's Phone#_____Physician's Name_____(over)

**Please list any medications you take periodically or regularly: --**

| Name Medication | Date First Taken | Name Medication | Date First Taken |
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**Are there any medications or foods that you are allergic to: -- Yes ☐ No ☐ If yes please list below:**

| Medications | | Foods | |
|---|---|---|---|
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Describe conditions checked as "OTHER" on the reverse side or any other unlisted health problems you feel we should know about.

**CONSENT AGREEMENT:**

This Consent Agreement is for the express purpose of substantiating that our patients have been informed of certain office practices and complications associated with oral surgery. In no way does it relieve the doctor of his responsibilities.

I, the undersigned, understand that fees for treatment are my obligation solely, irrespective of any determination my insurance company may make regarding said treatment and records and radiographs will be submitted only to duly authorized peer review committees of organized dentistry of medicine.

**I consent to the recording of clinical photographs for educational and record-keeping purposes.**

I, furthermore, certify that the medical history given by me is true and hereby authorize the doctors and assistants to perform the necessary surgery and treatment, and such additional operations or procedures as are therapeutically indicated on the basis of findings during the course of said operation. This will include the administration of such anesthetics as are necessary in the judgment of the doctor. I fully understand the above authorization for treatment, the reasons why the treatment is considered necessary and its advantages and possible complications, including swelling, bleeding, loss of tooth parts or fillings, sinus involvement, infection, jaw fracture, temporary and permanent numbness, vein inflammation, untoward drug reactions, and other complications. No guarantees or assurances have been made to me as to the results that may be obtained.

Information given by: --

Signature X_____ Date_____

Doctor/Staff Use Only (Additional Notes)