Dental Health History Form

Patient Name ____ **Phone Number** _____________________________

Address ____

Date of Birth ___ ___ /___ ___/___ ___ ___ ___ **Social Security Number** ___ ___ ___-___ ___- ___ ___ ___ ___

Health History

1. Circle any of the following that you have or have had in the past:

Blood Pressure: high or low	Heart Disease	Heart Valve
Rheumatic Fever	Asthma/COPD	Stroke
Hepatitis	Tuberculosis	Seizures
Immunocompromised Disease	Stomach Problems (ulcers, reflux, etc.)	Joint Replacement
Thyroid Problems	Kidney Disease	Back Problems
Seasonal Allergies	Pancreatitis	Sinus Problems
Diabetes	Bleeding Problems	Cancer/Radiation
Pacemaker	Headaches	Hemophilia
Other:		

2. Have you ever had an allergic reaction to any of the following: (circle) ***Medication*** ***Food*** ***Latex***

   Please explain: ____

3. Please list all medications (prescribed and/or over-the-counter) that you are currently taking:

   ____
   ____
   ____

4. Please list any medications you are currently taking or have taken in the past for ***osteoporosis*** (i.e. Boniva, Actonel, Fosamax)____

5. Have you ever had a serious illness, operation, or been hospitalized? If so, please explain:

   ____

6. ***Women only***: a. Are you pregnant or do you think you may be pregnant? ***Yes*** ***No***

   b. Are you currently taking oral birth control: ***Yes*** ***No***

7. Please list your primary care doctor/provider and contact number:

   Medical Provider:__________________________________ Phone Number:__________________________

WHITE HOUSE CLINICS

DENTAL HEALTH HISTORY FORM

Social History

8. Do you use tobacco? ***Yes*** ***No***

   If yes: How much and what type: ______________________________

   How long have you used it: ______________________________

9. Do you now or have you ever use controlled substances (drugs) recreationally? ***Yes*** ***No***

10. Do you now or have you ever received treatment at a pain clinic? ***Yes*** ***No***

Dental History

11. What is the reason for your dental visit today?

    Exam ***Pain/Swelling*** ***Broken tooth/ Broken filling*** ***Cleaning*** ***Treatment***

12. How long has this been a problem or concern? ____

13. When was your last dental visit? ____

    Reason for that visit: ____

14. Have you ever been shown how to brush and/or floss? ***Yes*** ***No***

15. How many snacks do you eat per day (candy, pop, etc…)?

    None 1 – 2 Per Day 3 – 4 Per Day 5 – 6 Per Day More than 4 per day

The above information is accurate and complete, to the best of my knowledge, and is only for use in my treatment, billing and processing of insurance benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient/Guardian Signature____ Date_____________________

Dentist/Hygienist Signature____ Date_____________________

For Office Use Only:

Guardianship verification received: Date _________________________ Employee Initials______________