WHITE HOUSE CLINICS

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
NONE	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:_____

Continue on back.

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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

16. What pharmacy do you use:

    Pharmacy:_____ Phone Number:_____

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_____