PATIENT HEALTH HISTORY UPDATE

DENTAL HISTORY **TODAY'S DATE_____**

Name_____Date of Birth_____Date last Exam_____
Email_____
Date of last dental Full Mouth X-Ray _____
Reason for Today's visit_____
How often do you brush? _____How often do you floss? _____ Mouthwash? _____
Please check any of the following conditions that apply to you**:**

- ❑ Bad Breath
- ❑ Bleeding gums
- ❑ Clicking or popping jaw
- ❑ Food collection between teeth
- ❑ Grinding teeth
- ❑ Loose teeth or broken fillings
- ❑ Periodontal treatment
- ❑ Sensitivity to cold
- ❑ Sensitivity to heat
- ❑ Sensitivity to sweets
- ❑ Sensitivity when biting
- ❑ Sores or growths in you mouth

MEDICAL HISTORY

Physician_____Date of last visit_____
Physician Address_____
_____Phone#_____FAX#_____
Please list all medications you are currently taking; Use back if necessary: _____
_____
_____
Allergies: _____
(Women) Are you pregnant? Yes No. Nursing? Yes No. Taking birth control pills? Yes No.
Check if you have had any of the following:

- ❑ AIDS
- ❑ Anemia
- ❑ Arthritis, Rheumatism
- ❑ Artificial Heart Valves
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Back Problems
- ❑ Bleeding Abnormally
- ❑ Blood Disease
- ❑ Cancer
- ❑ Chemical Dependency
- ❑ Chemotherapy
- ❑ Circulatory Problems
- ❑ Congenital Heart Lesions
- ❑ Cortisone Treatments
- ❑ Cough, Persistent
- ❑ Cough up blood
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Fainting
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart Murmur
- ❑ Heart Problems; Describe_____
- ❑ Hemophilia
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Shortness of Breath
- ❑ Skin Rash
- ❑ Stroke
- ❑ Swelling of Feet; Ankles
- ❑ Thyroid Problems
- ❑ Tobacco Habit
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Venereal Disease
- ❑ Hepatitis
- ❑ Hernia Repair
- ❑ High Blood Pressure
- ❑ HIV Positive
- ❑ Jaw Pain
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Mitral Valve Prolapse
- ❑ Nervous Problems
- ❑ Pacemaker
- ❑ Psychiatric Care
- ❑ Radiation Treatment
- ❑ Respiratory Disease or COPD

Have you ever used **Bisphosphonate** medications; Fosamax, Boniva, etc. Yes No
Have you ever taken any of these medications? Please circle:

- Blood Thinners, Coumadin, Plavix, Aspirin, Metformin, Synthroid, >200mgPrednisone/day
- Asthma inhaler dependent, Nitroglycerine, Imitrex,

RESPONSIBLE PARTY

NAME SS# BIRTHDATE

HOME ADDRESS CITY STATE ZIP HOME PHONE# CELL PHONE#

EMPLOYER PRESENT POSITION HOW LONG EMPLOYED

BUSINESS ADDRESS CITY STATE ZIP PHONE#

DENTAL INSURANCE COMPANY GROUP NUMBER

ADDRESS OF THE INSURANCE COMPANY CITY STATE ZIP PHONE #

SPOUSE

NAME SS# BIRTHDATE

HOME ADDRESS IF DIFFERENT THAN ABOVE HOME PHONE# CELL PHONE#

NAME OF EMPLOYER PRESENT POSITION HOW LONG EMPLOYED

BUSINESS ADDRESS CITY STATE ZIP PHONE#

DENTAL INSURANCE COMPANY GROUP NUMBER

ADDRESS OF THE INSURANCE COMPANY CITY STATE ZIP PHONE#

CERTIFICATION AND ASSIGNMENT

To the best of my knowledge, the above information is true and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.
I certify that my above listed insurance coverage is assigned directly to Dr. Hacker and Dr. Johnson. I further assign all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Signature of patient, parent or guardian or personal representative Date