HEALTH HISTORY for All Smiles Dental

Date of Birth Height Weight Date

Answer all questions by circling Yes (Y) or No (N)

All responses are kept confidential

1. Are you in good health?.....Y N
2. Has there been any change in your general health in the past year?.....Y N
3. Date of last physical exam _____
4. Are you now under a physician's care for a particular problem?.....Y N
5. Have you **ever** had any serious illnesses, operations or hospitalizations? If so, describe:.....Y N

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6. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever or Rheumatic Heart Disease?.....Y N
   - B. Congenital Heart Disease?.....Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker)?.....Y N
   - D. Lung Disease (Asthma, Emphysema, COPD, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)?.....Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness?.....Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily?.....Y N
   - G. Liver Disease (Jaundice, Hepatitis)?.....Y N
   - H. Kidney Disease?.....Y N
   - I. Diabetes?.....Y N
   - J. Thyroid Disease (Goiter)?.....Y N
   - K. Arthritis?.....Y N
   - L. Stomach Ulcers or Colitis?.....Y N
   - M. Glaucoma?.....Y N
   - N. Osteoporosis?.....Y N
   - O. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)?.....Y N
   - P. Radiation (X-ray) treatment for Cancer?.....Y N
   - Q. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth?.....Y N
   - R. Sinus or Nasal problems?.....Y N
   - S. Any disease, drug or transplant operation that has depressed your immune system?.....Y N

7. **DO YOU HAVE ANY OTHER MEDICAL CONDITIONS NOT MENTIONED ABOVE? IF SO, PLEASE LIST:**

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8. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics?.....Y N
   - B. Anticoagulants (Blood Thinners)?.....Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen?.Y N
   - D. High Blood Pressure medications?.....Y N
   - E. Steroids (Cortisone, Prednisone, etc.)?.....Y N
   - F. Tranquilizers?.....Y N
   - G. Insulin or Oral Anti-Diabetic drugs?.....Y N
   - H. Digitalis, Inderal, Nitroglycerin or other heart drug?Y N
   - I. Are you taking or ***have you ever taken*** Bisphosphonates for osteoporosis, multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa, Prolia) ? .....Y N
   - J. Have you ever been advised <u>not</u> to take a medication? .....Y N
   - K. Please list any and all medications taken, including prescription medications, diet drugs, over-the-counter medications, herbal or holistic remedies, vitamins or minerals:_____

_____

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9. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novacain, etc.)?.....Y N
   - B. Penicillin or other antibiotics?.....Y N
   - C. Sedatives, Barbiturates?.....Y N
   - D. Aspirin or Ibuprofen?.....Y N
   - E. Codeine or other pain killers?.....Y N
   - F. Latex or Rubber products?.....Y N
   - G. Metal of any kind?.....Y N
   - H. Chemicals or jewelry (rash or sensitivity)?.....Y N
   - I. Food products?.....Y N
   - J. Other allergies or reactions? Please list.....Y N

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10. Do you smoke or chew Tobacco?.....Y N
    How much per day? _____
11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you?.....Y N
12. Have you had any serious problems associated with any previous dental treatment?.....Y N
13. Have you or an immediate family member had any problem associated with intravenous anesthesia?.....Y N
14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about?.....Y N
15. Do you wish to talk to the doctor privately about anything?.....Y N
16. Have you ever had a bone density scan?.....Y N
17. **FOR WOMEN ONLY**
    - A. Are you Pregnant, or **<u>is there any chance</u>** you might be Pregnant?.....Y N
    - B. Are you nursing?.....Y N
    - C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the importance of a truthful and complete Health History to assist my dentist in providing the best care possible. I have had the opportunity to discuss my Health History with my dentist and/or his staff. I understand it is my responsibility to fill out the form correctly and completely.

_____ _____ _____

Date Signature of Person Completing Health History Doctor's Initials

Name _____
Address _____
_____
E-mail _____

Best Phone Contact# _____
-if mobile number, service provider?_____

2nd Best Phone Contact# _____

Date of Birth: _____
Height:_____Weight:_____

Driver's License # _____

Social Security # _____

Marital Status:
__Single __Married __Divorced __Widowed
Spouse _____

Closest relative _____
-OR-
Emergency contact person and phone #
_____
_____

In order for us to provide you with exceptional quality of care, we like to get to know you better. As providers, all of the following is important to us; however, we would like to know *which is **most i**mportant to you?(please circle)*

Function
Comfort
Cosmetic
Longevity

When considering having *treatment* done, which of these would be of concern to you? *(please circle)*

Fear
Time
Budget
No sense of urgency
No trust

What is the most important quality for you in a relationship with a doctor?
_____
_____

Are you detail-oriented? Or do you prefer the bottom line?

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all smiles
EXPERIENCED, GENTLE CARE FOR THE FAMILY
(Formerly Crocker Dental)

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All Smiles Dental
PATIENT DISCLOSURE INSTRUCTIONS

In general, the **HIPAA** privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (*check all that apply*):

☐ Home Telephone _____

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication

- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to _____
- ☐ O.K. to text to cell phone

_____

☐ Work Telephone _____

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Other (Fax/Cell, etc.) _____

_____

☐ email address(es) _____

I allow you to give my clinical information to or answer questions from (*check all that apply*):

☐ Spouse
☐ Parent
☐ Child
☐ Other (specify): _____
☐ None

_____ _____
Patient Signature Date

_____ _____
Print Name Birth date

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