DENTAL HEALTH ASSOCIATES HEALTH FORM

Date: _____

Name: _____ (Last / First / Middle)
Home Phone: (____)_____
Cell Phone: (____)_____
Address: _____
Business Phone: (____)_____
City: _____ State: ____ Zip: _____
Date of Birth: ____/____/____ (Month / Date / Year)
E-Mail: _____
Occupation: _____ Employer: _____ S.S.#: ____/____/____
Name of spouse: _____
Business Phone: (____)_____
Occupation: _____ Employer: _____ S.S.#: ____/____/____

Dental Insurance Company #1

Dental Insurance Co.: _____
Business Phone: (____)_____
Group #: _____ This dental Insurance is provided through: Insured's Name: _____
Insured's S.S.#: ____/____/____ Insured's Birthdate: ____/____/____ (Month / Date / Year) Insured's Employer: _____

Dental Insurance Company #2

Dental Insurance Co.: _____
Business Phone: (____)_____
Group #: _____ This dental Insurance is provided through: Insured's Name: _____
Insured's S.S.#: ____/____/____ Insured's Birthdate: ____/____/____ (Month / Date / Yea) Insured's Employer: _____

In case of emergency, who should we contact other than spouse?
Name: _____ Relationship: _____ Phone: _____

Referred by: _____

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

1. Are you in good health ..... yes no
2. Has there been any changes in your general health within the past year? ..... yes no
3. My last physical exam was on: _____/_____/_____
4. Are you now under the care of a physician? ..... yes no
   If so, what is the condition being treated? _____
5. The name and address of your physician(s) is: _____ Phone: (____)_____
6. Have you had any serious illness, operation, or been hospitalized in the past 5 years? ..... yes no
   If so, what was the illness: _____
7. Are you taking any medicine(s) including non-prescription Medicine? ..... yes no
   If so, what medicine(s) are you taking? _____
8. Do you have or have you had any of the following diseases?
   a. Damaged heart valves or artificial heart valves, including heart murmur, rheumatic heart disease, rheumatic fever, or mitral valve prolapse? ..... yes no
   b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) ..... yes no
      1. Do you have chest pain upon exertion? ..... yes no
      2. Are you ever short of breath after mild exercise or when laying down? ..... yes no
      3. Do your ankles swell? ..... yes no
      4. Do you have a cardiac pacemaker? ..... yes no
   c. Allergy ..... yes no
   d. Sinus trouble ..... yes no
   e. Asthma or hay fever ..... yes no
   f. Fainting spells or seizures ..... yes no
   g. Diabetes ..... yes no
   h. Hepatitis, jaundice or liver disease ..... yes no
   i. AIDS or HIV infection ..... yes no
   j. Thyroid problems ..... yes no
   k. Respiratory problems, emphysema, bronchitis, etc ..... yes no
   l. Arthritis, painful swollen joints, or prosthetic joint replacement ..... yes no
   m. Stomach ulcer or hyperacidity ..... yes no

n. Kidney problems or renal dialysis ..... yes no
o. Tuberculosis ..... yes no
p. Persistent cough or cough that produces blood ..... yes no
q. Persistent swollen glands in neck ..... yes no
r. Low blood pressure ..... yes no
s. Sexually transmitted disease ..... yes no
t. Epilepsy or other neurological disease ..... yes no
u. Problems with mental health ..... yes no
v. Cancer ..... yes no

9. Have you had any abnormal bleeding? ..... yes no
   a. Have you ever required a blood transfusion? ..... yes no
10. Do you have any blood disorders such as anemia? ..... yes no
11. Have you ever had any treatment for a tumor or a growth? ..... yes no
12. Are you allergic or have you had a reaction to:
    a. Local anesthetics ..... yes no
    b. Penicillin or other antibiotics ..... yes no
    c. Barbiturates, sedatives, or sleeping pills ..... yes no
    d. Aspirin ..... yes no
    e. Codeine or other narcotics ..... yes no
    f. Other ..... yes no
13. Have you had any serious trouble associated with previous dental treatment? ..... yes no
    If so, explain:
14. Do you have any disease, condition, or problem listed above that you think we should know about? ..... yes no
    If so, explain:
15. Are you wearing contact lenses? ..... yes no
16. Are you wearing removal dental appliances? ..... yes no
17. Do you smoke or use any other tobacco products? ..... yes no

Women:

18. Are you pregnant? ..... yes no
19. Are you nursing? ..... yes no
20. Are you taking birth control pills ? ..... yes no

FOR OFFICE USE ONLY- PLEASE DO NOT FILL OUT

Dental History:

1. Chief dental complaint :_____
2. How long has it been since you last visited a dental office?_____ Last x-rays?_____
3. What was done for you at that time?_____
4. Why did you leave your last dentist? _____
5. Do any of your teeth ache, or are any sensitive to heat, cold or pressure? _____
6. Do you grind your teeth or clench your jaw? _____
7. Do you have frequent headaches? _____
8. Are you aware of any sores or growths in your mouth? _____
9. Have you ever had any complications during or following dental treatment? _____
10. How important are your natural teeth to you? 1 2 3 4 5 6 7 8 9 10
    NOT IMPORTANT VERY IMPORTANT
11. How do you feel about your smile? 1 2 3 4 5 6 7 8 9 10
    UNHAPPY HAPPY
12. Are your teeth white enough? ..... yes no
13. Are you concerned about bad breath? ..... yes no
14. Do you snore or have you been diagnosed with sleep apnea? ..... yes no

I certify that I have read and understand the above. I have acknowledge that my question, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for errors or omissions that I have made in completion of this form.

Signature of Patient:_____ Date:_____

Signature of Doctor:_____ Witness: _____