

# Health History Form



American Dental Association  
www.ada.org

E-mail:	Today's Date:
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As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: Last First Middle	Home Phone: <i>Include area code</i> ( )	Business/Cell Phone: <i>Include area code</i> ( )
Address: Mailing address	City:	State: Zip:
Occupation:	Height:	Weight: Date of birth: Sex: M F
SS# or Patient ID:	Emergency Contact:	Relationship: Home Phone: ( ) Cell Phone: ( ) <i>Include area codes</i>

If you are completing this form for another person, what is your relationship to that person?

Your Name	Relationship
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<b>Do you have any of the following diseases or problems:</b>	<b>(Check DK if you Don't Know the answer to the question)</b>			<b>Yes</b>	<b>No</b>	<b>DK</b>
Active Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Persistent cough greater than a 3 week duration.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cough that produces blood.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Been exposed to anyone with tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.**

## Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	No	DK		Yes	No	DK
Do your gums bleed when you brush or floss? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have earaches or neck pains? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does food or floss catch between your teeth? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you brux or grind your teeth? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your mouth dry?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have sores or ulcers in your mouth? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any periodontal (gum) treatments?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear dentures or partials? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had orthodontic (braces) treatment?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you participate in active recreational activities?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any problems associated with previous dental treatment?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a serious injury to your head or mouth?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your home water supply fluoridated? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of your last dental exam:			
Do you drink bottled or filtered water?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What was done at that time?			
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY				Date of last dental x-rays:			
Are you currently experiencing dental pain or discomfort?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
What is the reason for your dental visit today?							
How do you feel about your smile?							

## Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No	DK		Yes	No	DK
Are you now under the care of a physician? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a serious illness, operation or been hospitalized in the past 5 years? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physician Name: Phone: <i>Include area code</i> ( )				If yes, what was the illness or problem?			
Address/City/State/Zip:							
Are you in good health? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you taking or have you recently taken any prescription or over the counter medicine(s)? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has there been any change in your general health within the past year? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:			
If yes, what condition is being treated?				_____			
Date of last physical exam:				_____			

# Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

<b>(Check DK if you Don't Know the answer to the question)</b>			<b>Yes No DK</b>				<b>Yes No DK</b>				
Do you wear contact lenses? .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you use controlled substances (drugs)?.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Joint Replacement.</b> Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you use tobacco (smoking, snuff, chew, bidis)? .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date: _____ If yes, have you had any complications? _____						If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED					
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you drink alcoholic beverages? .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how much alcohol did you drink in the last 24 hours? _____					
Date Treatment began: _____						If yes, how much do you typically drink in a week? _____					
<b>Allergies</b> - Are you allergic to or have you had a reaction to: To all <b>yes</b> responses, specify type of reaction.			<b>Yes</b>	<b>No</b>	<b>DK</b>				<b>Yes</b>	<b>No</b>	<b>DK</b>
Local anesthetics _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Metals _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Latex (rubber) _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Iodine _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives, or sleeping pills _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever/seasonal _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Animals _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Codeine or other narcotics _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Food _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.</b>											
			<b>Yes</b>	<b>No</b>	<b>DK</b>				<b>Yes</b>	<b>No</b>	<b>DK</b>
Artificial (prosthetic) heart valve .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune disease .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous infective endocarditis .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damaged valves in transplanted heart .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Systemic lupus erythematosus. ....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart disease (CHD)						Asthma .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unrepaired, cyanotic CHD .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repaired (completely) in last 6 months .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repaired CHD with residual defects .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Tuberculosis .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.</i>						Cancer/Chemotherapy/ Radiation Treatment .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<b>Yes</b>	<b>No</b>	<b>DK</b>	Chest pain upon exertion .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular disease. ....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic pain .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angina .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Type I or II .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arteriosclerosis .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eating disorder.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congestive heart failure .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Malnutrition .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damaged heart valves.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal disease.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G.E. Reflux/persistent heartburn .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other congenital heart defects .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name of physician or dentist making recommendation:						Phone:					
Do you have any disease, condition, or problem not listed above that you think I should know about? .....											
Please explain:											

**NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.**  
 I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about 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 any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**FOR COMPLETION BY DENTIST**

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**WOODBURY**  
— DENTAL ASSOCIATES —

First Name:

Last Name:

D.O.B:

(For Patient's with Dental Insurance, Only)

I, \_\_\_\_\_, hereby authorize and request my insurance company to pay and hereby assign directly to Woodbury Dental Associates all dental benefits, if any, otherwise payable to me. I understand I am financially responsible for all charges whether or not paid by insurance. Authorization is hereby given to release all information necessary to secure the payment of said benefits. I authorize the use of this signature on all insurance submissions.

Today's Date:

Patient Signature or Responsible Party (if minor):

X \_\_\_\_\_

Proof of Insurance

We must obtain a copy of a current valid insurance card to provide proof of insurance. If you fail to provide the correct insurance information in a timely manner, you may be responsible for the balance of your claim. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

Treatment Plans, Estimates and Co-Payments

Our staff will provide you with an estimate of your out of pocket expenses and will require this amount to be paid at the time of the visit. We can only estimate the amount your insurance carrier may pay towards your services and cannot guarantee that any/or all procedures will be covered. Final determination is made by your insurance carrier and we will bill you for any remaining balance after they have paid.

Financial Policy and Payments:

We require all payments at the time services are rendered. We accept cash, check, or credit card. There is a return check fee of \$40.00 for any dishonored checks. 15% APR may be added to all accounts not paid in full within 45 days of completion of treatment or account due date. If the account becomes past due, you will be responsible for any collection costs or attorneys' fees incurred to collect the past due amounts.

Today's Date:

Patient Signature or Responsible Party (if minor):

X \_\_\_\_\_

### Photo Consent

(Initials) \_\_\_\_\_ I authorize the use of my x-rays and/or photographs for educational and promotional use.  
Consent is voluntary.

### Cancellation Policy

Your appointment is reserved just for you. We respect your time and make every effort to stay on schedule. If you must reschedule your appointment, we request at least 24 hour notice so that your reserved time may be given to another patient in need of dental care. We reserve the right to cancel, change, or move any appointment at any time. We will do our best to inform you of all changes. Any patient arriving more than 15 minutes late to any appointment is not guaranteed to be seen and may need to reschedule. Consecutively missed appointments may result in dismissal from the practice.

Today's Date:

Patient Signature or Responsible Party (if minor):

X \_\_\_\_\_



## Patient HIPAA Consent

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize Woodbury Dental Associates to use and disclose my protected health information to carry out:

- \*Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- \*Obtaining payment from third party payers (e.g. my insurance company)
- \*The day- to- day healthcare operations of the dental practice.

I have also been informed of and given the right to review and secure a copy of Woodbury Dental Associate's Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that Woodbury Dental Associates reserves the right to change the terms of this notice from time to time and that I may contact the office at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that Woodbury Dental Associates is not required to agree to these requested restrictions. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Patient or Responsible Party (if minor):

First Name:

Last Name:

D.O.B:

X \_\_\_\_\_

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