Print Form

DENTAL PARK

PATIENT HEALTH HISTORY

Thank you for taking a few minutes to complete the following information about your personal health history. This information is extremely important to the Doctor in determining your current and future care.

PLEASE INQUIRE ABOUT ANY QUESTIONS WHICH YOU DO NOT UNDERSTAND.

Patient Name: _____
Address:_____
City:_____
State: _____ Zip code: _____
Phone (home) _____
Phone (cell) _____
Email _____
Social Security #: _____

Physician Name: _____
Clinic Name: _____
Clinic Phone: _____

Birth date: ____/____/____ Sex: Male/Femal
Single / Married / Divorced/Separated / Ch
If Minor, parents names: _____
_____
Student: Full time / Part time
School: _____

Employer: _____
Occupation: _____
Phone (work) _____
Is it OK to contact you at work? **Yes / No**
Dental Insurance: Primary_____
Secondary_____
(We will make copies of any insurance cards)

CURRENT ILLNESS/CHIEF COMPLAINT: Describe your current problem and symptoms: ____
_____
_____

MEDICATIONS: Please list medications and dosages including inhalers, prescriptions, over-the-counter, vitamins, and "natural" medications:

MEDICATION	DOSAGE	MEDICATION	DOSAGE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you currently take medication for osteoporosis? **Yes / N**List Medication: _____

ALLERGIES: Please list allergies including medications, food, dyes, latex, metal, nickel, etc.

_____ _____ _____
_____ _____ _____

HOSPITALIZATION/ILLNESS:
Have you been hospitalized in the past year? **Yes / N** Undergone surgery? **Yes / N**
Are you currently under a physicians care for a medical problem or condition? **Yes / No**
List reasons for hospitalization and types of surgery including dates _____
_____
_____

SOCIAL HISTORY: Are you currently pregnant or nursing? **Yes / No**
Do you now or have you ever smoked? **Yes / No** If Yes, how much and how long? _____
What type of tobacco? Cigarette / Cigar / Pipe / Smokeless If you have quit, when? _____
Do you drink alcoholic beverages? **Yes / N** If Yes, list amount and frequency _____
Are you currently disabled? **Yes / N** Please describe your disability_____

Please continue on the other side

REVIEW OF SYSTEMS: Please check the medical conditions or symptoms that you have or have had in the past and briefly explain or list any other medical conditions we should be aware of:

HEAD AND NECK:
- ☐ Headaches
- ☐ Neck Pain
- ☐ Neck lumps/swelling
- ☐ Thyroid disease/goiter
- ☐ Jaw joint pain
- ☐ Limited neck movement
- ☐ History of radiation treatment

EARS:
- ☐ Hearing problems
- ☐ Earaches

EYES:
- ☐ Glaucoma

NOSE & THROAT:
- ☐ Sinus disease/infection
- ☐ Difficulty/pain swallowing

UROLOGIC:
- ☐ Kidney disease

DIGESTIVE:
- ☐ Heartburn
- ☐ Jaundice (yellow skin)
- ☐ Hepatitis/liver disease

NEUROLOGICAL:
- ☐ Stroke
- ☐ Convulsions/seizures
- ☐ Tremors
- ☐ Weakness/paralysis
- ☐ Numbness
- ☐ Memory problems/lapses
- ☐ Loss of balance

RESPIRATORY:
- ☐ Asthma/wheezing
- ☐ Emphysema
- ☐ Recent pneumonia
- ☐ Blood clots
- ☐ Tuberculosis

MUSCULOSKELETAL:
- ☐ Joint replacement(s) list:
  _____
  _____
- ☐ Back pains
- ☐ Arthritis/joint pain
- ☐ Muscle injury/aches

CARDIOVASCULAR:
- ☐ Heart attack
- ☐ Heart murmur
- ☐ High/low blood pressure
- ☐ Irregular heart beat
- ☐ Chest pain/pressure
- ☐ Dizzy spells/fainting
- ☐ Shortness of breath
- ☐ History of Rheumatic fever
- ☐ Heart valve problems
- ☐ Bleeding problems/disorders/ blood thinners

GENERAL:
- ☐ Cancer
- ☐ Diabetes
- ☐ Alcoholism/drug abuse
- ☐ Depression/nervous disorder
- ☐ Speech difficulties
- ☐ Anemia
- ☐ Sexually transmitted disease
- ☐ HIV/AIDS

Explanation:_____
_____
_____

Is there anything not included in this form that you would like your Doctor to know about you?
_____
_____

Is there anything you would like to/or wish you could change about your smile? _____
_____
_____

I give my permission to take necessary and/or routine xrays….. Yes / N ☐ _____ (initial)
I give my permission for the use of Nitrous oxide (laughing gas) Yes / N ☐ _____ (initial)
I give my permission for the use of local anesthetic……Yes / N ☐ _____ (initial)

The above information is true and correct to the best of my knowledge.
I accept the responsibility for the charges incurred by the patient and agree to pay bills at the time of service unless other arrangements are made. I authorize my insurance carrier to pay insurance claims directly to Dental Park. I further understand my insurance carrier may pay less than the actual bill for services and that any charges for services are ultimately my responsibility.

_____ _____
Patient Signature (Or Parent/Legal Guardian) Date

_____ _____
Patient (Parent or Legal Guardian) Printed Name Relationship to Patient

_____ _____
Doctor's Signature Date