Health History Form

Email: ______________________________ Today's Date: ______

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.

Patient and Account Information

Patient ____ ❐ M ❐ F Age______ Birthdate ________________

Business / Cell Phone ______________________________ Home Phone ______________________________________

Address ____ Social Security ___________________________________

______________________ Zip Code: __________ Referred by _______________________________________

❐ Single ❐ Married ❐ Widowed ❐ Separated ❐ Divorced

Occupation / Employer ____

Emergency Contact (relationship / phone)____

Dental Information

For the following questions, please mark (X) your responses to the following questions. **(check DK for Don't Know)**

	Yes	No	DK
Do your gums bleed when you brush or floss?	❐	❐	❐
Are your teeth sensitive to cold, hot, sweets or pressure?	❐	❐	❐
Does food or floss catch between your teeth?	❐	❐	❐
Is your mouth dry?	❐	❐	❐
Have you had any periodontal (gum) treatments?	❐	❐	❐
Have you ever had any problems associated with previous dental treatment?	❐	❐	❐
Is your home water supply fluoridated?	❐	❐	❐
Do you drink bottled water?	❐	❐	❐
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	❐	❐	❐

How often do you brush per day? ____________________

How often do you floss? ________________________

	Yes	No	DK
Do you have earaches or neck pains?	❐	❐	❐
Do you have any clicking, popping or discomfort in your jaw?	❐	❐	❐
Do you brux or grind your teeth?	❐	❐	❐
Do you have sores or ulcers in your mouth?	❐	❐	❐
Do you wear dentures or partials?	❐	❐	❐
Do you participate in active recreational activities?	❐	❐	❐
Have you ever had a serious injury to your head or mouth?	❐	❐	❐

Date of your last dental exam: ______________________________

Date of your last dental x-rays: ______________________________

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
Are you under the care of a physician?	❐	❐	❐

Physician Name: _______________________________________ Phone: ______________________________________

Address ____

	Yes	No	DK
Are you in good health?	❐	❐	❐
Has there been any change in your general health within the past year?	❐	❐	❐

If yes, what condition is being treated? ____

Date of last physical exam: ______________________________________

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	❐	❐	❐

If yes, what was the illness or problem? ____

	Yes	No	DK
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	❐	❐	❐

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:_______________________

____

(continued on back)

Northeast Dental Wellness

Medical Information

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

ALLERGIES –

Are you allergic to or have you had a reaction to:
TO ALL YES RESPONSES, SPECIFY TYPE OF REACTION.

	Yes	No	DK
Local anesthetics ____	❐	❐	❐
Aspirin ____	❐	❐	❐
Penicillin or other antibiotics ____	❐	❐	❐
Barbiturates, sedatives, or sleeping pills ____	❐	❐	❐
Sulfa drugs ____	❐	❐	❐
Codeine or other narcotics ____	❐	❐	❐
Metals ____	❐	❐	❐
Latex (rubber) ____	❐	❐	❐
Iodine ____	❐	❐	❐
Hay fever / seasonal ____	❐	❐	❐
Animals ____	❐	❐	❐
Food ____	❐	❐	❐
Other ____	❐	❐	❐

	Yes	No	DK
Do you use controlled substances (drugs)?	❐	❐	❐
Do you use tobacco (smoking, snuff, chew, bidis)?	❐	❐	❐
If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED	❐	❐	❐
Do you drink alcoholic beverages?	❐	❐	❐

If yes, how much alcohol did you drink in the last 24 hours? ____

If yes, how much do you typically drink in a week? ____

WOMEN ONLY Are you:

	Yes	No	DK
Pregnant?	❐	❐	❐
Number of weeks: ____			
Taking birth control pills or hormonal replacement?	❐	❐	❐
Nursing?	❐	❐	❐

JOINT REPLACEMENT

	Yes	No	DK
Have you had an orthopedic total joint (hip knee, elbow, finger) replacement?	❐	❐	❐
Date: ____ If yes, have you had any complications?	❐	❐	❐
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax) or risedronate (Actonel) for osteoporosis or Paget's disease?	❐	❐	❐

	Yes	No	DK
Artificial (prosthetic) heart valve	❐	❐	❐
Previous infective endocarditis	❐	❐	❐
Damaged valves in transplanted heart	❐	❐	❐
Congenital heart disease (CHD)	❐	❐	❐
Unrepaired, cyanotic CHD	❐	❐	❐
Repaired (completely) in last 6 months	❐	❐	❐
Repaired CHD with residual defects	❐	❐	❐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease	❐	❐	❐
Angina	❐	❐	❐
Arteriosclerosis	❐	❐	❐
Congestive heart valves	❐	❐	❐
Heart attack	❐	❐	❐
Heart murmur	❐	❐	❐
Low blood pressure	❐	❐	❐
High blood pressure	❐	❐	❐
Other congenital heart defects	❐	❐	❐
Mitral valve prolapse	❐	❐	❐
Pacemaker	❐	❐	❐
Rheumatic fever	❐	❐	❐
Rheumatic heart disease	❐	❐	❐
Abnormal bleeding	❐	❐	❐
Anemia	❐	❐	❐
Blood transfusion	❐	❐	❐
If yes, date: ____			

	Yes	No	DK
Hemophilia	❐	❐	❐
AIDS or HIV infection	❐	❐	❐
Arthritis	❐	❐	❐
Autoimmune disease	❐	❐	❐
Rheumatoid arthritis	❐	❐	❐
Systemic lupus erythematosus	❐	❐	❐
Asthma	❐	❐	❐
Bronchitis	❐	❐	❐
Emphysema	❐	❐	❐
Sinus trouble	❐	❐	❐
Tuberculosis	❐	❐	❐
Cancer/chemotherapy/ radiation treatment	❐	❐	❐
Chest pain upon exertion	❐	❐	❐
Chronic pain	❐	❐	❐

	Yes	No	DK
Diabetes Type I or II	❐	❐	❐
Eating disorder	❐	❐	❐
Malnutrition	❐	❐	❐
Gastrointestinal disease	❐	❐	❐
G.E. Reflux/persistent heartburn	❐	❐	❐
Ulcers	❐	❐	❐
Thyroid problems	❐	❐	❐
Stroke	❐	❐	❐
Glaucoma	❐	❐	❐
Hepatitis, jaundice or liver disease	❐	❐	❐
Epilepsy	❐	❐	❐
Fainting spells or seizures	❐	❐	❐
Neurological disorders	❐	❐	❐
If yes, specify: ____			
Sleep disorder	❐	❐	❐
Mental health disorders	❐	❐	❐
If yes, specify: ____			
Recurrent infections	❐	❐	❐
Type of infection:			
Kidney problems	❐	❐	❐
Night sweats	❐	❐	❐
Osteoporosis	❐	❐	❐
Persistent swollen glands in neck	❐	❐	❐
Severe headaches/migraines	❐	❐	❐
Severe or rapid weight loss	❐	❐	❐
Sexually transmitted disease	❐	❐	❐
Excessive urination	❐	❐	❐

	Yes	No	DK
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	❐	❐	❐

Name of physician or dentist making recommendation: ____ Phone: ____

	Yes	No	DK
Do you have any disease, condition, or problem not listed above that you think we 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 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 staff responsible for any action they make 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: ____

ACCOUNT RESPONSIBILITY

- I understand I am financially responsible for my account.
- I authorize Northeast Dental Wellness limited use for disclosure of my protected healthcare information for the purposes of my treatment or care, satisfaction of my account, or situations mandated by law.
- Further, I authorize my insurance company to make payments directly to Northeast Dental Wellness.

Patient Signature: ____ Date: _____________________

PRIVACY AND SECURITY PRACTICES

We are committed to maintaining your personal information both secure and confidential. Whether it is your medical information or identifiable information like name, address, phone number or identification numbers, we maintain careful safeguards to protect against unauthorized access or fraudulent use.

We may use your individual patient information to coordinate dental treatment with other healthcare providers. To lessen your patient costs, we may disclose personal information to determine insurance eligibility, claim status and payments, medical necessity of your treatment, insurance complaints, appeals or external review request. Situational uses may include those mandated by law: public health issues, abuse or neglect, legal proceedings, collection efforts, law enforcement, coroners, medical examiners or organ donation programs, research, worker's compensation and/or your employer.

You have a right to confidential communications, a right to request restrictions and a right to access your records. Restrictions can limit our efficiency and ability to help you.

As a creditor, we have a responsibility beyond protecting your information – identifying, detecting and responding to potential warning signs of identity theft or fraud as outlined by the Federal Trade Commission's Red Flags Rule.

DENTAL INSURANCE

In a changing healthcare environment and an era that many dentists do not accept the hassles of insurance, we consciously choose to help our patients seek insurance reimbursement. We understand that every dollar matters. With this decision, comes Federal and State regulations that we must comply with to continue being your advocate.

	Primary Insurance	Secondary Insurance
Place holder	______________________________	____
Date of Birth	______________________________	____
Individual Id/Social Security	________________	____
Employer	_________________________________	____
Insurance Company	________________________	____
Group Number	____________________________	____
Address	__________________________________	____