Patient Health History

Account ID ______________________________________
Date ____

Personal Information

Patient Name ___________________________________ Age ______
Name* Mr./Mrs./Miss/Ms. _________________________ SSN ______________
Spouse Mr./Mrs./Miss/Ms. _________________________ SSN ______________
Address ____
____
City _______________________________ State ________ Zip _____________
Phone __________________________________
Referred by ______________________________
**Person responsible for the account*

Employer and Insurance Information

Your Employer _____________________________________ Phone ____________________
Dental Insurance Co. _________________________________ Group No. _________________
Address ____
Coverage ___ Family ___Self and Dependants ___ Self Only

Spouse Employer ____________________________________ Phone __________________
Dental Insurance Co. __________________________________ Group No. ________________
Address ____
Coverage ___ Family ___Self and Dependants ___ Self Only

Patient Birthday ______________ Spouse Birthday ______________

Check the appropriate box, yes or no

Yes	No		Yes	No		Yes	No		*Allergic To:* Yes	No	
_	_	Anemia/Blood Disease	_	_	Fainting/Nervous	_	_	Mitral Valve Proplase			
_	_	Arthritis	_	_	Glaucoma	_	_	Neck/Head Pain	_	_	Aspirin
_	_	Asthma/Hay Fever	_	_	Heart Trouble	_	_	Pregnant	_	_	Codeine
_	_	Blood Pressure/High	_	_	Pacemaker	_	_	Rheu Fever	_	_	Local Anesthesia
_	_	Blood Pressure/Low	_	_	Hepatitis/Liver Disease	_	_	Stroke	_	_	Penicillin
_	_	Cancer/Tx/X-Ray	_	_	Herpes Virus	_	_	TB/Lung Disease	_	_	Sedatv/Tranq
_	_	Diabetes	_	_	HIV Positive/AIDS	_	_	TMJ/clicking joint	_	_	Premedicate
_	_	Epilepsy/Seizures	_	_	Joint Replacement	_	_	Venereal Disease	_	_	Medical Alert
_	_	Cardiovascular Disease (heart attack, angina, coronary occlusion, arteriosclerosis)	_	_	Migraine Headaches	_	_	Are you taking birth control pills?			

My physician is ____
Taking Medications __ Yes __ No If yes, ____
Allergic to Medications __ Yes __ No If yes, ____

Method of Payment __ Cash __ Check __ Insurance __ Credit Card

Date of Last Dental Treatment_____________________ Date previous X-Rays______________

Previous Dentist ____

____

What is you main concern with your teeth and mouth? __________________________________

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____

General Information

Comments____
____
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The Above information is true and complete to the best of knowledge. I agree to pay any and all charges not covered by my dental insurance. I also agree to pay my co-payment at time services are rendered (accounts 30 days past due will be charges a 1% monthly billing fee).

Patient Signature____________________________________ Date ______________________