DentisTree OF MANASSAS

Health History Form

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.

Patient Name:

Last: _____ First: _____ Birthdate: _____Sex: **M F**

Address: _____ City: _____ State: _____ Zip: _____

Cell: _____ Home Phone: _____ Social Security #: _____

Emergency Name: _____ Emergency Contact: _____

How would you like to be contacted? ❑ email ❑ cell phone (text) ❑ home phone Employer _____

Occupation _____ Spouse's name _____ ❑ Unmarried
Email: _____Whom may we thank for referring you to our office? _____

BILLING AND INSURANCE INFORMATION: ❑ Not covered by dental insurance

Dental Insurance Co._____ Group#: _____ Covered by spouse's or parent's insurance? ❑ yes ❑ no dental

Spouse's/parent insurance company _____ Spouse's/parent employer _____

Group number _____ Spouse's/parent birthday _____ Social Security#: _____

Dental History

Date of your last dental visit? _____Date of last dental x-rays: _____
Reason for today's visit? _____
Are you having any dental discomfort currently? _____
Have you had any problems associated with previous dental treatment? _____

Please check any that apply:	
❑ Is your mouth dry?	Are you interested in improving your smile? Y / N
❑ History of Dental Implants?	
❑ History of wisdom teeth extraction?	Are you interested in whitening your teeth? Y / N
❑ History of root canal?	
❑ Have you had any periodontal (gum) treatments?	Are you interested in straightening your teeth? Y / N
❑ Do you have any clicking, popping or discomfort in the jaw?	
❑ Do you grind your teeth?	Are you interested in replacing missing teeth? Y / N
❑ Do your gums bleed when you brush or floss?	
❑ Wear denture or partial denture?	
❑ History of Teeth whitening?	
❑ Are your teeth sensitive to cold, hot, sweets or pressure?	

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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? _____ Latex (rubber) : _____

Do you have or have you had any of the following? (Please check any that apply)

❑ Cancer or tumor
❑ Heart murmur, mitral valve prolapse, heart defect
❑ Rheumatic fever or rheumatic heart disease
❑ Artificial joint or valve
❑ Pacemaker
❑ kidney disease
❑ Hepatitis or other liver disease
❑ Blood transfusion
❑ Diabetes
❑ Emotional condition
❑ AIDS or HIV positive
❑ Anemia or blood disorders
❑ Abnormal bleeding after extractions, surgery, or trauma
❑ Migraine headaches or frequent headaches
❑ Heart ailment or angina
❑ Neurologic condition
❑ Arthritis
❑ High or low blood pressure
❑ Tuberculosis or other lung problems
❑ Epilepsy, seizures, or fainting spells
❑ Alcoholism
❑ Radiation treatment
❑ Asthma
❑ Herpes or cold sores
❑ Allergies or hives
❑ Asthma
❑ Hay fever or sinus trouble
❑ Stroke

Are you taking any of the following?

❑ Aspirin ❑ Anticoagulants (blood thinners) ❑ Antibiotics or sulfa drugs
❑ High blood pressure medicine ❑ Antidepressants or tranquilizers
❑ Insulin, Orinase, or other diabetes drug ❑ Nitroglycerin ❑ Cortisone or other steroids
❑ Osteoporosis (bone density) medicine (bisphosphonates) ❑
Other medications you take: _____

Women: ❑ May be pregnant. Expected delivery date: _____ ❑ Taking hormones/contraceptives

Name of your primary Doctor:_____

Do you have any disease, condition, or problem not listed above?_____

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**:_____