Health History Form

ADA American Dental Association®
America's leading advocate for oral health

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.

Name: *Last* *First* *Middle*

Home Phone: *Include area code* ( )

Business/Cell Phone: *Include area code* ( )

Address: *Mailing address*

City: State: Zip:

Occupation:

Height: Weight: Date of Birth: Sex: M F

SS# or Patient ID: Emergency Contact: Relationship:

Home Phone: *Include area code* ( )

Cell Phone: *Include area code* ( )

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

Your Name *Relationship*

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the the question)*

	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

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
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐

If yes, how often? *Circle one:* DAILY / WEEKLY / OCCASIONALLY

	Yes	No	DK
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the 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:

What was done at that time?

Date of 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 now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

	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 dietary supplements:

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Medical Information

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

(Check DK if you Don't Know the answer to the question)

	Yes	No	DK
Do you wear contact lenses?			
Joint Replacement. 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~~ an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease?			
Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Date Treatment began:			

	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: Pregnant? Number of weeks: _____ Taking birth control pills or hormonal replacement? Nursing?			

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 _____			

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

	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 failure			
Damaged 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: _____			
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			
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			
Do you snore?			
Mental health disorders 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			

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

Name of physician or dentist making recommendation:

Phone: *Include area code* ( )

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:

Signature of Dentist: Date:

Comments: FOR COMPLE TON BY DENTIST

Patient Screening Form

ADA

Patient Name:

	PRE-APPOINTMENT	IN-OFFICE
	Date:	Date:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they having shortness of breath or other difficulties breathing?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have a cough?	☐ Yes ☐ No	☐ Yes ☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they experienced recent loss of taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they in contact with any confirmed COVID-19 positive patients? *Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.*	☐ Yes ☐ No	☐ Yes ☐ No
Is your/their age over 60?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	☐ Yes ☐ No	☐ Yes ☐ No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

- For testing, see the list of State and Territorial Health Department Websites for your specific area's information.

Patient Acknowledgment of

Receipt of the California Dental Materials Fact Sheet

I acknowledge that I have received a copy of the Dental Materials Fact Sheet dated May 2004

Yo acepto haber recivido copia de el Dental Materials Fact Sheet con pecha de Mayo 2004

_____ _____

Patient/ Parent or Guardian Name (printed) Date

_____

Patient Name/ Parent or Guardian Signature

HIPAA COMPLIANCE

Patient Consent to Receive Mail and/or Telephone Messages

Patient's Name: (*Please print*)

LAST NAME FIRST NAME MIDDLE

1. Do we have your permission to send recall/treatment appointment reminders to your home? Yes ☐ No ☐

2. Do we have your permission to leave the following information on your home answering machine or voice mail?

Appointment Information	Yes ☐	No ☐
Billing Information	Yes ☐	No ☐
Dental/Medical Information	Yes ☐	No ☐

3. Do we have your permission to leave the following information on your work answering machine or voice mail?

Appointment Information	Yes ☐	No ☐
Billing Information	Yes ☐	No ☐
Dental/Medical Information	Yes ☐	No ☐

4. Do we have your permission to send the following information to your e-mail address provided to us on your patient registration form?

Appointment Information	Yes ☐	No ☐
Billing Information	Yes ☐	No ☐
Dental/Medical Information	Yes ☐	No ☐

5. Do we have your permission to send the following information to your cell phone number (including text messages) provided to us on your patient registration form?

Appointment Information	Yes ☐	No ☐
Billing Information	Yes ☐	No ☐
Dental/Medical Information	Yes ☐	No ☐

6. Do we have your permission to send the following information to your fax machine at the number provided to us on your patient registration form?

Appointment Information	Yes ☐	No ☐
Billing Information	Yes ☐	No ☐
Dental/Medical Information	Yes ☐	No ☐

7. I hereby give permission to share any Information concerning me with the person(s) named below:

Name: _____ Name: _____

DATE: _____

SIGNED: _____ **WITNESS:** _____

Print Name: _____ Print Name: _____

Relationship to Patient: Self ☐ Spouse ☐ Parent ☐ Child ☐ Legal Guardian ☐ Other: ☐