ADA American Dental Association
www.ada.org

Health History Form

Patient Information

Name: _____ Preferred name: _____
LAST FIRST MIDDLE INITIAL

Address: _____ City: _____ State: _____ Zip Code: _____
P.O. BOX or Mailing Address

Home Phone: ( ) Cell Phone: ( ) Email: _____

DOB: _____ Relationship status: Single / Married / Partnered / Divorced / Separated / Widowed

Occupation: _____ Employer: _____ Employer Phone: ( )

SS no.: _____ Emergency Contact: _____ Relationship: _____ Phone: ( )

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

How did you hear about our office? * _____

Other family members seen here: _____

Insurance Information

Please give your insurance card to the receptionist and fill out the following information to the best of your ability. This will help us determine insurance coverage that may be applied to this visit. If the subscriber information is the same as above, you may leave this section blank.

Person responsible for the bill: _____ Relationship to patient: _____
LAST FIRST MIDDLE INITIAL

Home Phone: ( ) Cell Phone: ( )

Address: _____ City: _____ State: _____ Zip Code: _____
P.O. BOX or Mailing Address

Email: _____ Occupation: _____ Employer: _____

Is this person a patient here? ❑ Yes ❑ No Patient's primary dental insurance: _____

Insurance subscriber's name: _____ Subscriber's S.S. no.: _____ Birth date: _____
LAST FIRST

Patient's relationship to subscriber: _____ Ins. group no.: _____ Policy no.: _____ Co-payment: $

For the following questions, please (X) whichever applies, your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit 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 optimal care for you. This office does not use this information to discriminate.

Dental Information

What is the reason for your visit today? _____

Do you have any additional dental concerns? _____

How do you feel about the appearance of your teeth? _____

What would you like to learn more about? _____

Date of last dental visit: _____ What was done at that time? _____

Date of last dental cleaning (if different): _____

Date of last full mouth x-rays (if different): _____

How often do you brush your teeth? _____

Generally, how often do you floss? _____

Do your gums bleed when you brush? _____

Have you experienced:	**Yes**	**No**	**DK**
Clicking or popping of the jaw?	❑	❑	❑
Difficulty in opening or closing the mouth?	❑	❑	❑
Difficulty in chewing on either side of the mouth?	❑	❑	❑
Headaches, neck aches or shoulder aches?	❑	❑	❑

	Yes	**No**	**DK**
Have you had any periodontal (gum) treatments?	❑	❑	❑
Are your teeth sensitive to cold, hot, sweets or pressure?	❑	❑	❑
Have you ever had orthodontic treatment?	❑	❑	❑
Do you have earaches or neck pains?	❑	❑	❑
Do you clench or grind your teeth while awake or asleep?	❑	❑	❑
Do you wear removable dental appliances?	❑	❑	❑
Do you mouth breath while awake or asleep?	❑	❑	❑
Do you have tired jaws, especially in the morning?	❑	❑	❑
Do you snore or have any other sleeping disorder?	❑	❑	❑

Medical Information

If you answer yes to any of the 3 items below, please stop and return This form to the receptionist.

Have you had any of the following diseases or problems?	Yes	No	DK
Active Tuberculosis	❑	❑	❑
Persistent cough greater than a 3-week duration	❑	❑	❑
Cough that produces blood	❑	❑	❑
Are you in good health?	❑	❑	❑
In the past year, has there been any change in your general health?	❑	❑	❑
Are you now under the care of a physician?	❑	❑	❑

If yes, what is/are the condition(s) being treated? Please explain below.

Are you taking, or have you recently taken, any medication(s) including non-prescription medications? ❑ ❑ ❑

If yes, please list any prescribed medication(s): _____

Do you use tobacco (smoking, snuff, chew)? ❑ ❑ ❑

If yes, how interested are you in stopping?

Do you drink alcoholic beverages? ❑ ❑ ❑

Are you allergic to or have you had a reaction to any of the following items?

Local anesthetics	❑	❑	❑
Aspirin	❑	❑	❑
Penicillin or other antibiotics	❑	❑	❑
Barbiturates, sedatives, or sleeping pills	❑	❑	❑
Sulfa drugs	❑	❑	❑
Codeine or other narcotics	❑	❑	❑
Latex	❑	❑	❑
Iodine	❑	❑	❑

Date of last physical examination: _____

Physician: _____
NAME

( )
PHONE ADDRESS

CITY/STATE ZIP

In the past 5 years have you experienced any of the following situations?	Yes	No	DK
Serious illness, operation, or been hospitalized	❑	❑	❑

If yes, what was the illness or problem? _____

Have you had an orthopedic total joint replacement? ❑ ❑ ❑

If yes, what was the date of the surgery?

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

If yes, what antibiotic and dose?

Name of physician or dentist (if different from above):

Phone: ( )

Women Only

Please answer the following to the best of your knowledge.

Are you or could you be pregnant?	❑	❑	❑
Nursing?	❑	❑	❑
Taking birth control pills or hormonal replacement?	❑	❑	❑

Allergies continued.

To any yes allergy responses, please specify type of reaction.

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

Abnormal bleeding	❑	❑	❑	Hemophilia	❑	❑	❑
AIDS or HIV infection	❑	❑	❑	Hepatitis, jaundice or liver disease	❑	❑	❑
Anemia	❑	❑	❑	Mental health disorders	❑	❑	❑
Arthritis or Rheumatoid arthritis	❑	❑	❑	If yes, specify:			
Asthma	❑	❑	❑	Malnutrition	❑	❑	❑
Blood transfusion. If yes, date:	❑	❑	❑	Neurological disorders	❑	❑	❑
Cancer/Chemotherapy/Radiation Treatment	❑	❑	❑	If yes, specify:			
Chronic pain	❑	❑	❑	Night sweats	❑	❑	❑
Chest pain upon exertion	❑	❑	❑	Osteoporosis	❑	❑	❑
Diabetes. If yes, specify:	❑	❑	❑	Persistent swollen glands in neck	❑	❑	❑
Disease, drug, or radiation-induced immunosuppression	❑	❑	❑	Respiratory problems.	❑	❑	❑
Dry Mouth	❑	❑	❑	If yes, please specify: Emphysema, Bronchitis, etc.	❑	❑	❑
Eating disorder. If yes, specify:	❑	❑	❑	Severe headaches/migraines	❑	❑	❑
Epilepsy	❑	❑	❑	Severe or rapid weight loss	❑	❑	❑
Fainting spells or seizures	❑	❑	❑	Sexually transmitted disease	❑	❑	❑
Gastrointestinal disease	❑	❑	❑	Sinus trouble	❑	❑	❑
G.E. Reflux/persistent heartburn	❑	❑	❑	Sleep disorder	❑	❑	❑
Glaucoma	❑	❑	❑	Sores or ulcers in the mouth	❑	❑	❑
Recurrent Infections	❑	❑	❑	Stroke	❑	❑	❑
Kidney problems	❑	❑	❑	Systemic lupus erythematosus	❑	❑	❑
Cardiovascular disease.	❑	❑	❑	Tuberculosis	❑	❑	❑
If yes, specify:				Thyroid problems	❑	❑	❑

NOTE: Both Doctor and patient are encouraged to discuss all relevant patient health issues prior to treatment. I certify that I have read and understand the above. 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 _____