Mission Prosthodontics

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CONFIDENTIAL HEALTH HISTORY

Today's Date:

PATIENT REGISTRATION INFORMATION			
Name:		Marital Status:	
Date of Birth:	Age:	Home Phone:	Cell Phone:
Current Address:			
City:	State:	Zip Code:	
VISIT INFORMATION			
Name of General Dentist:	City:	How Long?:	
Referred to this office by:		City:	
Reason for This Visit:			
EMPLOYMENT INFORMATION			
Occupation:		Work Phone:	
Employer Name:		Can we contact you at work? Yes □	
SPOUSE INFORMATION			
Spouse Name:	Date of Birth:	Phone:	
Employer Name:		Employer Phone:	
EMERGENCY CONTACT			
Name of emergency contact:		Relationship to you:	
Address:		Phone:	
City:	State:	Zip Code:	
INSURANCE INFORMATION			
Insurance Holder (Checked Applicable): □ Patient	□ Spouse	□ Both	□ Other (relationship to you):
Name of Dental Plan or Insurance Company:		Name of Dental Plan or Insurance Company:	
Name of Group Dental Plan:		Name of Group Dental Plan	
Group #:		Group #:	
Union Local #:	SSN:	Union Local #:	SSN:

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes □/ No □ Is your general health good? If NO, explain: _____
2. Yes □/ No □ Has there been a change in your health within the last year?
   If YES, explain: _____
3. Yes □/ No □ Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain: _____
4. Yes □/ No □ Are you being treated by a physician now? If YES, explain: _____
   Date of last exam: _____ Reason for exam?: _____
5. Yes □/ No □ Have you had problems with prior dental treatment?
   If YES, explain: _____
   Date of last dental exam: _____ Name of last treating dentist: _____
6. Yes □/ No □ Are you in pain now? If YES, explain: _____

II. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING recently? (Please circle Yes for each)

Chest pain (angina)	Yes □	Blood in stools	Yes □	Frequent vomiting	Yes □
Fainting spells	Yes □	Diarrhea or constipation	Yes □	Jaundice	Yes □
Recent significant weight loss	Yes □	Frequent urination	Yes □	Dry mouth	Yes □
Fever	Yes □	Difficulty urinating	Yes □	Excessive thirst	Yes □
Night sweats	Yes □	Ringing in ears	Yes □	Difficulty swallowing	Yes □
Persistent cough	Yes □	Headaches	Yes □	Swollen ankles	Yes □
Coughing up blood	Yes □	Dizziness	Yes □	Joint pain or stiffness	Yes □
Bleeding problems	Yes □	Blurred vision	Yes □	Shortness of breath	Yes □
Blood in urine	Yes □	Bruise easily	Yes □	Sinus problems	Yes □

III. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please circle Yes for each)

Heart disease	Yes □	AIDS/HIV	Yes □	Psychiatric care	Yes □
Family history of heart disease	Yes □	Surgeries	Yes □	Osteoporosis	Yes □
Heart attack	Yes □	Hospitalization	Yes □	Thyroid disease	Yes □
Artificial joint	Yes □	Diabetes	Yes □	Asthma	Yes □
Stomach problems or ulcers	Yes □	Family history of diabetes	Yes □	Hepatitis (A, B or C)	Yes □
Heart defects	Yes □	Tumors or cancer	Yes □	Sexual transmitted disease	Yes □
Heart murmurs	Yes □	Chemotherapy	Yes □	Herpes	Yes □
Rheumatic fever	Yes □	Radiation	Yes □	Canker or cold sores	Yes □
Skin disease	Yes □	Arthritis, rheumatism	Yes □	Anemia	Yes □
Hardening of arteries	Yes □	Emphysema or other lung	Yes □	Liver disease	Yes □
High blood pressure	Yes □	Kidney or bladder disease	Yes □	Eye disease	Yes □
Seizures	Yes □	Stroke	Yes □	Transplants	Yes □
Cosmetic surgery	Yes □	Eating disorders	Yes □	Tuberculosis	Yes □

Other: _____

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please circle Yes for each)

Aspirin	Yes □	Valium	Yes □	Tetracycline	Yes □
Penicillin	Yes □	Demerol	Yes □	Vicodin	Yes □
Codeine	Yes □	Darvon	Yes □	Percodan	Yes □
Latex	Yes □	Food	Yes □	Nitrous oxide	Yes □
Local anesthetic (Novocain or Xylocaine)	Yes □	Erythromycin	Yes □	Metal	Yes □

Other: _____

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING recently? (Please circle Yes for each)

Recreational drugs	Yes □	Weight loss medications	Yes □	Antibiotics	Yes □
Bisphosphonate (Fosamax)	Yes □	Alcohol	Yes □	Aspirin	Yes □

Tobacco in any form If YES, how much? Yes □ _____

Please List Medications: _____

_____

VI. WOMEN ONLY (Please circle Yes or No for each

Yes □/ No □ Are you or could you be pregnant? If YES, what month? _____

Yes □/ No □ Are you nursing?

Yes □/ No □ Are you taking birth control pills?

VII. ALL PATIENTS (Please circle Yes or No for each)

Yes □/ No □ Do you have or have you had any other diseases or medical problems NOT listed on this form? If YES, please explain: _____

Yes □/ No □ Have you ever been pre-medicated for dental treatment? If YES, why?: _____

Yes □/ No □ Are you aware of grinding or clenching your teeth?

Yes □/ No □ Is there any issue or condition that you would like to discuss with the dentist in private?

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician. Yes or No?

_____ _____

Physician's Name Phone Number

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

X _____ _____ X _____ _____

Patient's Signature Date Dentist's Signature Date

MEDICAL UPDATES

I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	PATIENT SIGNATURE	CHANGES TO HEALTH HISTORY	DENTIST INITIALS