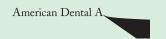
Health History Form

E-mail:	TodayÕs 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

does not use this information to	discriminate.								
Name:				Home Phone: In	clude area code	Business/Cell Phones	nclude area code	е	
Last	First	Middle		()		()			
Address:				City:		State:	Zip:		
Mailing address									
Occupation:				Height:	Weight:	Date of birth:	Sex: I	M	F
SS# or Patient ID:	Emergency Contact:			Relationship:		Home Phone:	Cell Phon	e:	
				·		() (()		
If you are completing this form	for another person, what is your r	olotione	hin to	that parcan?		Include area codes			
in you are completing this form	ioi another person, what is your i	eialions	nip to	that person:					
Your Name				Relationship					
Do you have any of the followi	·			•	•	now the answer to the question)		No	DK
	a 3 week duration							n	n
, ,	a 3 week duration							n	III
"	tuberulosis							ID.	m II
	e 4 items above, please stop and							0 0	0 0
Dental Informa	tion For the following questions	s nleas	e mar	k (X) vour respo	inses to the fo	ollowing questions			
		Yes No		K (X) your respe		mowning questions.	Voc	No	DK
Do your gums bleed when you	brush or floss?			Do you have e	araches or no	eck pains?		n	n
	d, hot, sweets or pressure?		n			opping or discomfort in the ja			n
l *	een your teeth?		n			eeth?			
	een your teenre								n
'	(gum) treatments?		n			s in your mouth? rtials?			n
1 1	.0		n						n
	c (braces) treatment?	n n	n			recreational activities?			n
Have you had any problems ass	•		_	Have you e	ver nad a seri	ious injury to your head or m	ioutn?n	n	
	مد المعادلة.		n	Date of your la	ast dental exa	m:			
'	oridated?		n	What was don	e at that time	?			
	water?		n						
	DAILY / WEEKLY / OCCASIONALL			Date of last de	ental x-rays:				
Are you currently experiencing	dental pain or discomfort?	n n	n						
What is the reason for your de	ntal visit today?								
How do you feel about your sn	nile?								

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

Yes No DK Have you had a serious illness, operation or been
hospitalized in the past 5 years? n n
If yes, what was the illness or purblem?
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 diet supplements:

(Check DK if you Don't Know the answer to the question)			DK				DK	
Do you wear contact lenses?	n	n	n	Do you use controlled substances (drugs)? Do you use tobacco (smoking, snuff, chew, bidis)?				
knee, elbow, finger) replacement?		n	n	If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED			"	
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosama) or risedronate (Actonel) for osteoporosis or PagetÕs disease?	n	m	m	Do you drink alcoholic beverages?				
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from PagetÕs disease, multiple myeloma or metastatic cancer?	n			WOMEN ONLY Are you: Pregnant? Number of weeks: Taking birth control pills or hormonal replacement? Nursing?	n	n n	n n	
Allergies - Are you allergic to or have you had a reaction to:		No	DK				DK	
To allyes responses, specify type of reaction. Local anesthetics	n	m	n	MetalsLatex (rubber)		_n_ _n		
Aspirin	n	n	n	lodine	n	n		
Penicillin or other antibiotics			n	Hay fever/seasonal		<u>n</u>		
Barbiturates, sedatives, or sleeping pills		n _n	n n	AnimalsFood		_n _n		
Codeine or other narcotics	n	_n		Other		n		
Please mark (X) your response to indicate if you have or have not have	d any	,	the fo	ollowing diseases or problems. Yes No DK	Yes	No	DK	
Has a physician or previous dentist recommended that you take a	antib	iotic	es pri	or to your dental treatment?	n.	n	n	
Name of physician or dentist making commendation:				Phone:			_	
Do you have any disease, condition, or problem not listed above that you think I should know about?						n		
NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment. I cettify that I have read and understand the above and that the information given on this form is accurate. I understand the impdance 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:				
FOR Comments:	CC	MP	LET	ION BY DENTIST				