

# NEW PATIENT HEALTH HISTORY FORM



## Personal Information

Patients Name \_\_\_\_\_ Parent or Guardian Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone Number \_\_\_\_\_ Email \_\_\_\_\_

## Dental Information

|  |   |   |  |   |   |
|--|---|---|--|---|---|
| Do your gums bleed when you brush or floss?                          | Y | N | Do you have earaches or neck pains?                      | Y | N |
| Are your teeth sensitive to cold, not, sweets or pressure?           | Y | N | Do you have any clicking, popping, or discomfort in jaw? | Y | N |
| Does food or floss catch between your teeth?                         | Y | N | Do you brux or grind your teeth?                         | Y | N |
| Is your Mouth dry?   | Y | N | Do you have sores or ulcers in your mouth?               | Y | N |
| Have you had any periodontal (gum) treatments?                       | Y | N | Do you wear dentures or partials?                        | Y | N |
| Have you ever had orthodontic treatment?                             | Y | N | Do you participate in active recreational activities?    | Y | N |
| Have you had any problems associated with previous Dental treatment? | Y | N | Have you ever had a injury to your head or mouth?        | Y | N |
| Are you currently experiencing dental pain or discomfort?            | Y | N | Date of your last Dental Exam? _____                     |   |   |
| How many times a day do you brush? _____                             |   |   | What was done at that exam? _____                        |   |   |
| How many times a week do you floss? _____                            |   |   |  |   |   |
| What is the reason for your dental visit today? _____                |   |   |  |   |   |
| How do you feel about your smile? _____                              |   |   |  |   |   |

## Medical Information

|  |   |   |  |   |   |
|--|---|---|--|---|---|
| Are you now under the care of a physician?   | Y | N | Physician Name: _____  |   |   |
| Address/City/State/Zip: _____  |   |   |  |   |   |
| Are you in good health?  | Y | N | Are you taking any prescription or over the counter medications? | Y | N |
| Has there been change in your health in the past Year?   | Y | N | If so, please list all medications:                              |   |   |
| If yes, what condition is being treated?   |   |   | _____  |   |   |
| _____  |   |   | _____  |   |   |
| _____  |   |   | _____  |   |   |
| Date of last physical exam: _____  |   |   | Do you use tobacco (smoking,snuff,chew)?                         | Y | N |
| Joint Replacement. Have you had an orthopedic total joint(hip, Knee, elbow, finger) replacement? | Y | N | If so, how interested are you in stopping?                       |   |   |
| Date: _____  |   |   | (Check one) VERY SOMEWHAT NOT INTERESTED                         |   |   |
| WOMEN ONLY: Are you pregnant?  | Y | N |  |   |   |
| Number of weeks? _____   |   |   |  |   |   |
| Taking birth control pills or hormonal replacement?  | Y | N |  |   |   |

ALLERGIES: Are you allergic to or have you had a reaction to:  
(To all yes responses, specify type of reaction)

|  |   |   |                                  |   |   |
|--|---|---|----------------------------------|---|---|
| Local anesthetics _____                          | Y | N | Metals _____                     | Y | N |
| Aspirin _____                                    | Y | N | Latex (rubber) _____             | Y | N |
| Penicillin or other antibiotics _____            | Y | N | Iodine _____                     | Y | N |
| Barbiturates, sedatives, or sleeping pills _____ | Y | N | Food _____                       | Y | N |
| Sulfa drugs _____                                | Y | N | Codeine or other narcotics _____ | Y | N |
| Other _____                                      | Y | N |                                  |   |   |

Please mark your response if you have or have not had any of the following diseases or problems.

|                                      |   |   |   |   |   |
|--------------------------------------|---|---|---|---|---|
| Artificial (prosthetic) heart valve  | Y | N | Autoimmune disease                      | Y | N |
| Previous infective endocarditis      | Y | N | Rheumatoid arthritis                    | Y | N |
| Damaged valves in transplanted heart | Y | N | Systemic lupus erythematosus            | Y | N |
| Congenital heart disease             | Y | N | Asthma                                  | Y | N |
| Cardiovascular disease               | Y | N | Emphysema                               | Y | N |
| Angina                               | Y | N | Tuberculosis                            | Y | N |
| Arteriosclerosis                     | Y | N | Cancer/Chemotherapy/Radiation Treatment | Y | N |
| Congestive heart failure             | Y | N | Chest pain upon exertion                | Y | N |
| Damaged heart valves                 | Y | N | Chronic pain                            | Y | N |
| Heart Attack                         | Y | N | Sexually Transmitted disease            | Y | N |
| Heart murmur                         | Y | N | Diabetes Type I or II                   | Y | N |
| Low blood pressure                   | Y | N | Eating disorder                         | Y | N |
| High blood pressure                  | Y | N | Malnutrition                            | Y | N |
| Other congenital heart defects       | Y | N | Gastrointestinal disease                | Y | N |
| Mitral valve prolapse                | Y | N | G.E. Reflux/persistent heartburn        | Y | N |
| Pacemaker                            | Y | N | Ulcers                                  | Y | N |
| Rheumatic Fever                      | Y | N | Thyroid problems                        | Y | N |
| Abnormal bleeding                    | Y | N | Stroke                                  | Y | N |
| Anemia                               | Y | N | Glaucoma                                | Y | N |
| Blood transfusion                    | Y | N | Hepatitis, jaundice or liver disease    | Y | N |
| Hemophilia                           | Y | N | Epilepsy                                | Y | N |
| AIDS or HIV infection                | Y | N | Fainting spells or seizures             | Y | N |
| Arthritis                            | Y | N | Neurological disorders                  | Y | N |
| Recurrent Infections                 | Y | N | Kidney problems                         | Y | N |
| Osteoporosis                         | Y | N | Persistent swollen glands in neck       | Y | N |
| Severe headaches/migraines           | Y | N | Severe or rapid weight loss             | Y | N |

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax) or risedronate (Actonel), intravenous bisphosphonates (Aredia or Zometa) for osteoporosis or Paget's Disease? Y N

Date Treatment began: \_\_\_\_\_

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

Name of physician or dentist making recommendation: \_\_\_\_\_ Phone # \_\_\_\_\_

Do you have any disease, condition, or problem not listed above that you think I should know about? Y N

Please explain: \_\_\_\_\_  
\_\_\_\_\_

#### CONSENT FOR TREATMENT

Assignment and Authorization: I hereby consent to an xray, laboratory procedures, anesthesia, medical or surgical treatments rendered the patient which Dr. David J. Coates may consider or advise in the treatment of my case and guarantee payments of the charges incurred. I hereby authorize the above named doctor to release information requested on this form. I understand that half of my portion of the charges is due at the time of service, and the other half is due within 60 days from the date that service was rendered, I know I am responsible for payment of my account.

Terms: Net 30 days from the date of the invoice unless otherwise indicated above. A finance charge of 1-1/2% per month (annual percentage rate 18%) of the unpaid balance will be added monthly. Should collection become necessary, the responsible party agrees to pay an additional 33.33% collection fee, and all legal fees of collection, with or without suit, including attorney fees and court cost.

Guests Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent or Guardian Signature(who is responsible for guest) \_\_\_\_\_