New Patient Health History

Name: ____ Phone #: (___)____-_____

Address:____

Street City State Zip Mobile #

Primary Care Physician: ______________________________ Phone #: (___)____-____

Are you currently taking any medications, including regular doses of aspirin? YES NO

If so, please list name and dosage ____

Are you aware of having an allergic reaction to any medication or substance? YES NO

If so, please list ____

Have you been under the care of a medical doctor during the past two years? YES NO

If so, for what ____

Have you seen an ear nose and throat doctor? YES NO Name: ____________

Have you seen a chiropractor? YES NO Name: ____________

Have you seen a neurologist? YES NO Name: ____________

Have you seen an orthodontist? YES NO Name: ____________

Do you take any pre-medication (antibiotics) for dental procedures? YES NO

Did some one refer you to the office? YES NO Name: ____________

Have you ever had a whiplash injury? YES NO When: ____________

Indicate by circling either yes or no for each items in which you have presently or had in the past

Congenital Heart Failure YES NO
Heart Murmur YES NO
Mitral Valve Prolapse YES NO
Artificial Heart Valve YES NO
Pacemaker YES NO
Stroke YES NO
Artificial Joint(s) YES NO
Liver Disease/Jaundice YES NO
Kidney Trouble YES NO
Trigeminal Neuralgia YES NO
HIV / AIDS YES NO
Neurological Disorders YES NO
Radiation/Chemotherapy YES NO
Psychiatric/Psychological YES NO
Asthma YES NO
Epilepsy / Seizures YES NO
Latex Sensitivity YES NO
Hepatitis YES NO
Tingling arms/fingers YES NO
Sickle Cell Disease YES NO
Bell's palsy YES NO
Difficulty Swallowing YES NO
Acid Reflux YES NO
Diabetes YES NO
Insomnia/Frequent Waking YES NO
High Blood Pressure YES NO

Jaw Pain YES NO
Jaw Popping YES NO
Limited Opening YES NO
Congested Ears YES NO
Dizziness YES NO
Ringing Ears YES NO
Loose Teeth YES NO
Postural Problems YES NO
Clenching YES NO
Grinding YES NO
Facial Pain YES NO
Sensitive Teeth YES NO
Neck Ache YES NO
Headache YES NO
Does floss shred when you use it? YES NO
Does food pack or catch between your teeth? YES NO
Do you smoke or chew tobacco? YES NO
Do your gums bleed? YES NO
Does your breath concern you? YES NO
Do you feel sleepy during the day? YES NO

Do you use a CPAP/BiPAP machine or have performed a sleep study? YES NO

Have you ever been told you snore or stop breathing during sleep? YES NO

Do you have or had any disease, condition, syndrome, or problem no listed? ________________

Women: Are you: Pregnant ____ Nursing ____ Take birth control pills ____

(CONTINUED ON FOLLOWING PAGE)

Emergency Contact Information

Primary:______________ Phone # (____)______-______

Secondary:______________ Phone # (____)______-______

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider who may release such information to you. I will notify the doctor of any change in my health or medication.

Signature: ____ Date: _____/_____/_____
Patient or Legal Guardian

Social Security Number _____-_____-_____ Date of Birth: ____/_____/_____

Email Address: ___________________________________

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