FOREST HILLS

DENTAL CARE

HEALTH HISTORY FORM

It is important that we know about your Medical and Dental History. These facts have a direct bearing on your dental health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

PERSONAL INFORMATION

Patient's Name _____ (FIRST NAME) _____ (MIDDLE INITIAL) _____ (LAST NAME)

Nickname _____ Date of Birth _____ Sex ☐ M ☐ F

Address _____ (STREET) _____ (APT #)

_____ (CITY) _____ (STATE) _____ (ZIP)

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____ SSN _____

Employer's Name _____ Occupation _____

Full Name of Spouse / Parent _____ Date of Birth _____ SSN _____

Spouse / Parent Employer _____ Occupation _____

REFERRAL SOURCE

Whom may we thank for this referral? _____

EMERGENCY CONTACT

Information of a relative NOT living with you

Name _____ Relation _____

Daytime Phone _____ Cell Phone _____

MEDICAL HISTORY

Previous Dentist _____ Physician's Name _____ Phone Number _____

Do you have any CURRENT HEALTH PROBLEMS? ☐ Y ☐ N If yes, what? _____

List Current Medications (or please attach on a separate page) _____

List any ALLERGIES you have to Medications _____

(Women) Are you Pregnant? ☐ Y ☐ N Nursing? ☐ Y ☐ N Taking Birth Control Pills? ☐ Y ☐ N

Circle any of the following which you have had or have at present:

Anemia	Arthritis, Rheumatism	Artificial Heart Valve
Artificial Joints, Pins, Etc.	Asthma	Back Problems
Bleeding Abnormally	Blood Disease	Chemical Dependency
Cancer	Chemotherapy	Circulatory Problems
Congenital Heart Lesions	Cortisone Treatments	Diabetes
Epilepsy	Fainting	Glaucoma
Sinus Problems	Headaches	Heart Murmur
Heart Problems	Hemophilia	Hepatitis
Skin Rash	Hernia Repair	High Blood Pressure
HIV/AIDS	Jaw Pain	Pacemaker
Kidney Disease	Liver Disease	Mitral Valve Prolapse
Radiation Treatment	Stroke	Respiratory Disease
Rheumatic Fever	Scarlett Fever	Shortness of Breath
Ulcer	Swelling Feet/Ankles	Thyroid Problems
Tobacco Habit		

Recreational Drugs (such as Marijuana) _____ Last time used _____

Other(s) _____

_____ _____

DOCTOR SIGNATURE DATE

CONSENT

The undersigned hereby authorize Doctor to take x-rays, study models, photographs, or any diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read and answered the above questions to the best of my knowledge. I understand that I am financially responsible for all charges whether or not they are paid by insurance. I authorize the use of my signature on all insurance submissions. I assign all insurance benefits to the Doctor.

_____ _____

PATIENT SIGNATURE (GUARDIAN) DATE

FOREST HILLS DENTAL CARE

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