

Health Information and History

Patient's Name: _____ **Date of Birth:** _____

If You are Completing This form For Another Person:

Your Name: _____ Phone: _____ Relationship: _____

Emergency Contact:(If Not Listed Above)

Name: _____ Phone: _____ Relationship: _____

Primary Physician: _____ **Phone:** _____ **City & State:** _____

Date of Last Physical Examination: _____ **Date of Last Blood Test/Workup:** _____

Other Physicians & Specialists

Name: _____ Specialty: _____ Phone: _____ City & State: _____

Name: _____ Specialty: _____ Phone: _____ City & State: _____

Within the Last 3 Years Have You Been Hospitalized or Had Surgery? Yes No

If Yes, Please Give Reasons and Dates: _____

Have You Ever Been Instructed to Take ANY Medications or Take ANY Special Precautions Before Any Dental Appointments*? Yes No

If Yes, Please Explain: _____

1. Are You Taking ANY Drugs, Medications, or Treatments at This Time? Yes No

(If You Brought a Complete Written List With You, Give That to the Receptionist Instead)

Prescribed _____

u. Over- The- Counter Medications (Such as Aspirin, Advil, Allergy Medication, Sleeping Aids, Etc.)

v. Vitamins, Natural or Herbal Preparations and/or Dietary Supplements

x. Are You Having or Ever Had Radiation or Chemotherapy Treatments*? Yes No

If Yes, for How Long? _____ Name of Facility Performing the Therapy: _____

2. Are You Allergic to or Have You Ever Experienced an Unusual Reaction to:

___ Latex ___ Metals or Jewelry ___ Dental Anesthesia (Local)

___ Fluoride ___ Nitrous Oxide (Laughing Gas) ___ General Anesthesia

3. Are You Allergic to or Have You Ever Had Any Reaction to Any of the Following Drugs?

___ Penicillin (or Related Drugs) ___ Tranquilizers (Valium) ___ Tetracycline ___ Codeine

___ Aspirin / Ibuprofen (Advil, Motrin, Nuprin) ___ Keflex (Cephalexin) ___ Sulfa Drugs ___ Iodine

___ NSAID (Celebrex, Vioxx, Anaprox) ___ Clindamycin (Cleocin) ___ Erythromycin

3z. Have You Had An Allergic Reaction or Unusual Response to ANY Other Medications, Drugs, Pills, or Treatments? Yes No

If Yes, Please List : _____

Continued on Next Page....

Do You Have or Have You Ever Had Any of the Following (Please Check Yes or No for Each Question)

- | | Yes | No |
|--|-----|-----|
| 4. a. Congenital Heart Defects* | ___ | ___ |
| b. Angina or Chest Pains | ___ | ___ |
| c. Atherosclerosis | ___ | ___ |
| d. Congestive Heart Failure | ___ | ___ |
| e. Coronary Artery Disease | ___ | ___ |
| f. Heart Surgery | ___ | ___ |
| If Yes, Date _____ | | |
| g. Heart Attack | ___ | ___ |
| If Yes, Date _____ | | |
| h. Rheumatic Heart Disease / Rheumatic Fever* | ___ | ___ |
| i. Heart Murmur* | ___ | ___ |
| j. Heart Valve(s) Damage / Mitral Valve Prolapse* | ___ | ___ |
| k. Artificial Heart Valve* | ___ | ___ |
| l. Pacemaker | ___ | ___ |
| m. Stroke or CVA | ___ | ___ |
| n. High Blood Pressure | ___ | ___ |
| o. Low Blood Pressure | ___ | ___ |
| p. Anemia | ___ | ___ |
| q. Hemophilia or Bleeding Disorder | ___ | ___ |
| r. Excessive Bleeding from Any Cut or Incident | ___ | ___ |
| s. Diabetes or Blood Sugar Problems | ___ | ___ |
| t. Any Artificial Joint, Joint Surgery, or Prosthesis* | ___ | ___ |
| If Yes, What Joint or Area: _____ | | |
| When was Operation Done: _____ | | |
| u. Hepatitis, Jaundice, or Other Liver Problems | ___ | ___ |
| v. Any Form of Cancer | ___ | ___ |
| w. An Organ Transplant* | ___ | ___ |

- | | Yes | No |
|--|-----|-----|
| 5. a. Asthma | ___ | ___ |
| b. Hay Fever, Skin or Food Allergies
or Allergies in General | ___ | ___ |
| c. Sinus Problems | ___ | ___ |
| d. Tuberculosis, Emphysema or Lung Disorder | ___ | ___ |
| e. Skin Problems | ___ | ___ |
| f. A Sore or Wound that Bleeds Easily
or Does not Heal | ___ | ___ |
| g. A Thyroid Problem or Disease | ___ | ___ |
| h. Arthritis | ___ | ___ |
| i. Glaucoma or Any Eye Diseases | ___ | ___ |
| j. Epilepsy or Other Seizure Disorder | ___ | ___ |
| k. Any Kidney Problems | ___ | ___ |
| l. Ulcers, Acid Reflux, or Stomach Problems | ___ | ___ |
| m. A Compromised Immune System*
(Lupus, HIV, AIDS, Radiation Immune Problem, etc) | ___ | ___ |
| n. An Active Sexually Transmitted Disease (STD) | ___ | ___ |
| o. Any Mental Health Issues | ___ | ___ |
| p. Been Treated for Any Psychiatric Condition | ___ | ___ |

- | 6. Women Only: | Yes | No |
|--|-----|-----|
| Are You Pregnant | ___ | ___ |
| If Yes, What is Your Due Date: _____ | | |
| Do You Think You Might Be Pregnant | ___ | ___ |
| Are You Presently Nursing | ___ | ___ |
| Are You Using Birth Control Medication | ___ | ___ |
| Are You Taking Hormone Replacement Therapy | ___ | ___ |

7. Do You Have Any Other Conditions, Diseases, or Medical Problems, or is There ANY Other Information That You Would Like Us to Know About or That We Should Be Made Aware Of?

If So, Please Explain: _____

Dental and Oral Health Information

If You are a New Patient to the Benjamin Dental Group:

Date of Last Dental Visit _____ Dentist's Name _____ City & State _____

Please Describe Any Specific Dental Problem or Discomfort You Are Having at This Time.

_____ How Long Has It Been Present? _____

If You Have Had Any of the Following Dental Care Please List the Dentists and Approximate Dates:

Periodontal (Gum) Treatment or Surgery _____

"Braces" or Any Type of Orthodontic Treatment: _____

Dental Implants: _____

Any Other Type of Oral Surgery: _____

Do You Have or Had Any of the Following or Noticed Any of These Signs or Symptoms in Your Head, Neck, or Mouth:

(Please Check Yes or No for Each Question)	Yes	No		Yes	No
Teeth that are Sensitive to:			A Clicking, Snapping or Difficulty When Chewing?	___	___
Heat, Cold, Sweets, or Biting Pressure?	___	___	Difficulty Opening or Moving the Jaws?	___	___
An Unpleasant Taste or Persistent Bad Breath?	___	___	Difficulty Speaking or Changes in Your Voice?	___	___
Does Food Catch Between Your Teeth?	___	___	Difficulty Moving Your Tongue or "Tongue Tied"	___	___
Do Your Gums Bleed When Brushing?	___	___	Loose or Separating Teeth?	___	___
Red, Swollen, Tender, Bleeding or Sores Gums?	___	___	Changes in the Way Your Teeth Fit Together?	___	___
Gums That Have Pulled Away from the Teeth?	___	___	A Color Change of the Tissues in Your Mouth?	___	___
Pus Between the Teeth and Gums?	___	___	Pain, Tenderness, Numbness, or Earaches?	___	___
Avoid Any Area When Brushing or Chewing?	___	___	Any Lumps Swelling or Swollen Glands?	___	___
Do You Clench or Grind Your Teeth?	___	___	Sores, Ulcers, or Rough Spots in Your Mouth?	___	___

Your Dental Health:

How Do You Rate Your Overall Dental Health? Good Fair Poor

How Many Times a Day Do You Brush Your Teeth? _____ How Many Times a Week Do You Floss Your Teeth? _____

Do You Use Any of the Following? (Please Check Yes or No for Each Question)

	Yes	No
Mechanical (Electric) Toothbrush?	___	___
If Yes, What Type or Brand? <input type="checkbox"/> Sonicare <input type="checkbox"/> Oral-B/Braun <input type="checkbox"/> Disposable <input type="checkbox"/> Other _____		
Flossing Aids? (Floss Holders, Threaders, Etc.)	___	___
Oral Irrigating Device (Water Pik)?	___	___
Fluoride Treatments or Supplements at Home? If Yes, What: _____	___	___
Mouthwashes or Oral Rinses? If Yes, What Brand? _____	___	___

Do You Have Any Missing Teeth That Have Not Been Replaced? _____

Why Have You Not Had Them Replaced? _____

Do You Wear Any Removable Dental Appliances? If Yes, What Type and For How Long? _____

Have You Ever Had Your Teeth Whitened or Bleached? _____

Would You Like to Have Your Teeth Whitened or Bleached? _____

How Do You Feel About the Appearance of Your Smile and What Else Would You Change If You Could? _____

Are You Concerned About the Finances Required to Return Your Mouth to Excellent Health? _____

Are You Frustrated Because You Always Need Something Treated or Repaired When You Visit a Dentist? _____

Do You Feel You Will Eventually Wear Artificial Dentures? _____

Have You Ever Had Any Complications From An Extraction or Dental Treatment? _____

If Yes, Please Explain _____

Have You Ever Had Any Other Dental Conditions, Major Trauma or Injury to Your Head, Neck, or Mouth? _____

If Yes, Please Specify: _____

Oral Health Risk Factors

1. Do You or Have You EVER Smoked?

Yes No

(If No, Proceed to Question 2)

The Amount that You are Presently Smoking

- None (Quit Smoking Completely)
- An Occasional Cigarette*
- A Few Cigarettes Daily*
- Less than 1 Pack of Cigarettes per Day*
- 1-2 Packs of Cigarettes per Day*
- 2 or More Packs of Cigarettes per Day*
- An Occasional Cigar*
- Cigars on a Daily / Regular Basis *
- An Occasional Pipe Smoker*
- A Pipe on a Daily / Regular Basis*

If You Have Quit Smoking, When Did You Quit?

- Less than 6 Months Ago*
- 6 Months to a Year*
- 1 to 3 Years Ago*
- Over 3 Years Ago

How Many Years Have You or Did You Smoked?

- Less than 2 Years
- 2-5 Years
- 5-10 Years
- 10-20Years
- Over 20 Years

2. Do You or Have You EVER Chewed Tobacco or Used Snuff?

Yes No

(If No, Proceed to Question 3)

Are You STILL Using Smokeless Tobacco or Snuff?*

Yes No

If No, WHEN Did You Quit?

- Less than 6 Month Ago*
- 6 Months to a Year*
- 1 to 3 Years Ago*
- Over 3 Years Ago

How Many Years Did You or Have You Used Smokeless Tobacco?

- Less than 1 Year
- 1-2 Years
- 2-5 Years
- Over 5 Years*

3. Approximate Average Amount of Alcoholic Beverages Presently Consumed per Week?

- None
- Less than 1 per Week
- 1-5 Drinks
- 6-10 Drinks
- 11-20 Drinks
- Over 20 Drinks*

4. Do You Have or Have You Ever Had a Substance Abuse Problem?*

Yes No

Describe _____

5. Do You Presently Use Any Recreational Drugs?*

Yes No

List _____

6. Do You Have or Have You Ever Had an Eating Disorder?*

Yes No

If Yes, Please Specify: _____

7. Do You Have or Ever Had Any Head, Neck or Mouth Piercing(s)? (Other than Ears)

Yes No

List _____

APPOINTMENTS— A minimum charge will be made for failed or canceled appointments without prior notification of at least 48 hours. This fee covers only a portion of the overhead such as salaries, electric, heat, etc., which still has to be paid whether you are present or not. Once an appointment is made, please remember this time has been reserved just for you. Any change in your appointments affects many patients; please be considerate.

INSURANCE—For your convenience, we will complete any forms required by your dental insurance company. Your signature below authorizes the release of any information regarding your dental claims to your insurance carrier(s). It also authorizes payment directly to our office. It is your responsibility, however, to cover the balance of treatment cost, or to cover the entire cost if your insurance should fail to provide coverage. We do not render our services on the basis that insurance will pay any or all of our charges. Each fee is individual for the individual patient.

PAYMENT— Payment is expected when services are rendered, unless other arrangements are made in advance. A service charge of 2% per month (equivalent to 24% PER ANNUM), will be added to the unpaid balance of all accounts over 30 days. In the event we must hire an attorney or collection agency to collect this debt, you will be responsible for the payment of all costs and expenses, including all collection agency fees, court costs and reasonable attorney's fees.

CONSENT—To the best of my knowledge, all of the preceding answers are correct. If I ever have any change in my health, or if my medications change, I will inform this office at the next appointment without fail. I hereby consent to allow diagnosis, proper dental care and treatment to be performed by this practice for myself or the above named individual until further notice. I understand there are no guarantees or warranties in health or dental care.

Signature _____ Date _____

(Parent or Guardian, if Patient is a Minor)

Office Use Only _____ HH04-1