# PERSONAL INFORMATION - HEALTH HISTORY
## Comprehensive Exam

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**NAME** _____ **Birthdate**:_____ Social Security no._____

MAILING ADDRESS_____City/State/Zip_____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

Who can we thank for your referral? _____

**PHONES:** Home: _____ Work: _____ FAX: _____

Cell: _____ pager: _____ email: _____

**OCCUPATION**:_____ **EMPLOYER** & address_____

Spouse's **Name**_____ **EMPLOYER** & address_____

**ACCOUNT RESPONSIBILITY** if someone other than yourself: NAME_____

Their Social Security No.: _____ Occupation:_____

Emergency contact number_____ Daytime Phone_____

**INSURANCE** : If you have dental insurance, we will provide you with receipt documentation than can be attached to your insurance company form for proper filing. You will receive a reimbursement directly for whatever you are entitled to. **The most important thing for you to know is the amount of your "calendar year maximum"** which you can find by calling your insurance carrier.
I understand that I will be charged a minimum of $127 for any cancelled, failed or missed appointment when notifying the office less than 48 business hours.

**HEALTH HISTORY** (please check if you have or had any of the following:)

| | | | |
|---|---|---|---|
| ☐ Yes ☐ No | Are you in good health? | ☐ Yes ☐ No | Diabetes |
| ☐ Yes ☐ No | Has your health changed in the last year | ☐ Yes ☐ No | Tumors, cancer |
| ☐ Yes ☐ No | Chest pain, shortness of breath | ☐ Yes ☐ No | Radiation treatment |
| ☐ Yes ☐ No | Bleeding problems, bruise easily | ☐ Yes ☐ No | Psychiatric care |
| ☐ Yes ☐ No | Headaches, ringing in ears | ☐ Yes ☐ No | Kidney or bladder disease |
| ☐ Yes ☐ No | Joint pain or stiffness, arthritis | ☐ Yes ☐ No | VD, herpes |
| ☐ Yes ☐ No | Fainting or seizures | ☐ Yes ☐ No | HIV positive, AIDS, ARC |
| ☐ Yes ☐ No | Heart disease, murmurs, rheumatic fever, prosthetic heart valve | ☐ Yes ☐ No | Pregnant: month_____ |
| ☐ Yes ☐ No | Pacemaker | ☐ Yes ☐ No | Birth control Pills |
| ☐ Yes ☐ No | High Blood pressure | ☐ Yes ☐ No | Smoking / alcohol |
| ☐ Yes ☐ No | Hepatitis or liver disease | | _____BP _____Pulse |
| ☐ Yes ☐ No | TB, asthma or lung disease | | |

List any and all **ALLERGIES:**_____

List any and all **DRUGS/MEDICATIONS** you are taking:_____

List any and all **SURGERIES:**_____

☐ Yes ☐ No Are you being treated by a Doctor now? Who?_____

**The above information is true and correct to the best of my knowledge:**

PATIENT SIGNATURE: _____ DATE:_____

# GETTING TO KNOW YOU
# Comprehensive Exam

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NAME: _____DATE: _____

**What name would you like us to call you?** _____

**Please describe the reason for your consultation today:**

_____

_____

_____

_____

**How long has this been going on and what other events apply to today's visit?**

_____

_____

**Why have you decided to deal with this now?**

_____

**Have you consulted with any other dentist about this? ☐ Yes ☐ No If yes, what was discussed or done?**

_____

_____

**When was your last dental check up?** _____

**Who is your regular or previous dentist?** _____

**Have you noticed or has any dentist or hygienist ever said that you:**

| | | | |
|---|---|---|---|
| **Have gum disease (gingivitis)** | **☐ Yes ☐ No** | **Lip or cheek biting** | **☐ Yes ☐ No** |
| **Grind your teeth** | **☐ Yes ☐ No** | **Loose or broken teeth or fillings** | **☐ Yes ☐ No** |
| **Clicking or popping jaw** | **☐ Yes ☐ No** | **Food collection between teeth** | **☐ Yes ☐ No** |
| **Jaw Pain or tiredness** | **☐ Yes ☐ No** | **Sores, blisters or growths** | **☐ Yes ☐ No** |
| **Pain around ear** | **☐ Yes ☐ No** | **Bad Breath** | **☐ Yes ☐ No** |

**Sensitivity to: ☐ cold ☐ heat ☐ sweets ☐ when biting or chewing**

**What are your priorities and what would you like to see done now?**

_____

_____

_____