Health History Form

Patient Name:_____ Date of Birth:_____

Dental History

Has the patient experienced any of the following:

Y	N	
☐	☐	Bad Breath
☐	☐	Grinding/Clenching
☐	☐	Bleeding Gums
☐	☐	Clicking/Popping Jaw
☐	☐	Periodontal Treatment
☐	☐	Sensitivity to hot/cold
☐	☐	Chipped teeth/Broken Fillings
☐	☐	Finger, Tongue or Thumb Habit
☐	☐	Day-time Mouth Breathing
☐	☐	Snoring/Sleep Apnea

If you checked yes to any of the above, please explain below:

Other/Details _____

Does the patient take vitamins with Fluoride? Yes_____ No_____

Medical History

Physician's Name: _____ Phone Number:_____

Address: _____ City: _____ State: _____ Zip: _____

Has the patient had any major surgeries? If so, please provide type/date:

_____

Check all that apply:

___ADD/ADHD
___ANEMIA
___ARTHRITIS
___ANXIETY
___ABNORMAL BLEEDING
___AUTISM/ASPERGERS
___BONE DISORDERS
___CANCER/TUMOR
___CEREBRAL PALSY
___DOWN SYNDROME
___DIZZINESS
___EPILEPSY/SEIZURES/FAINTING
___HERPES
___HEARING IMPAIRMENT
___HIGH BLOOD PRESSURE
___HIV/AIDS
___HEMOPHILIA
___HEART COMPLICATIONS
___HEPATITIS
___KIDNEY ISSUES
___MEASLES
___NERVOUS DISORDERS
___RHEUMATIC/SCARLET FEVER
___SINUS PROBLEMS
___SICKLE CELL DISEASE
___SINUS PROBLEMS
___TONSILLITIS
___TUBERCULOSIS

Allergies/Medications

Check all that apply:

___Metal/Nickel
___Latex/Rubber
___Acrylic
___Milk/Casein
___Other

If other, please explain:_____

Please list any medications patient is currently taking:_____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my/the patients health.

Signature:_____ **Date:**_____