Medical Alert:

FOR OFFICE USE ONLY

Dr. W. Henry, Dr. B. Mostaghaci & Associates

PID# _____

Private & Confidential Health History and Personal Information

Welcome to our office. Your overall health is important to us. We strive to treat all patients in a safe and effective manner, therefore we need to ask you some detailed questions related to your general health.

Today's Date ____/____/____ (D / M / Y)

(Dr., Mr., Mrs., Miss., Ms.)

Name _____ (Last / First / Initial)

Date of Birth ____/____/____ (D / M / Y)

Home Phone _____ **Office** _____ **Cell** _____

Street Address _____ Town/City _____

Postal Code _____ E-mail: _____

Occupation _____ Were you referred? Name of person _____

Marital Status _____ Employer _____

Personal Physician _____ Telephone _____

Account and Insurance Information

Person responsible for account? Self____Other _____

Do you have dental insurance? No____ / Yes____ Name of Company _____

We can pre-print or file your insurance claims electronically. Please provide the details of your insurance coverage.

Plan #_____ Cert # _____

Medical History

yes	no		Details
❑	❑	Do you have any allergies? (medications, latex, hayfever, food)	
❑	❑	Have you ever taken penicillin?	
❑	❑	Have you ever been advised to take antibiotics prior to a dental visit?	
❑	❑	Are you presently being treated for any medical condition?	
❑	❑	Have you been a patient in a hospital in the past 2 years?	
❑	❑	Have you had general surgery? Type and date?	
❑	❑	Have you ever had excessive bleeding that needed special treatment?	
❑	❑	Do you bruise easily?	
❑	❑	Do you have any history of heart trouble? (congenital heart disease, chest pains, angina, infective endocarditis, heart attack)	
❑	❑	Do you wear a pacemaker?	
❑	❑	Have you ever had rheumatic fever?	
❑	❑	Do you smoke or chew tobacco? How much per day?	
❑	❑	Are you pregnant or breast feeding? If pregnant, when is the expected due date?	

Please list all medications, non-prescription drugs and herbal supplements you are presently taking.

_____

_____

_____

_____

Please continue on the other side, thank you...

Do you have or have you had any of the following?

yes	no		yes	no		yes	no	
❑	❑	high blood pressure	❑	❑	glaucoma	❑	❑	depression
❑	❑	heart murmur	❑	❑	HIV/AIDS	❑	❑	epilepsy/seizures
❑	❑	artificial heart valve	❑	❑	hepatitis A	❑	❑	ADD/ADHD
❑	❑	stroke	❑	❑	hepatitis B	❑	❑	nerve disorders
❑	❑	anemia	❑	❑	hepatitis C	❑	❑	arthritis
❑	❑	asthma	❑	❑	scarlet fever	❑	❑	osteoporosis
❑	❑	respiratory/lung disease	❑	❑	thyroid condition	❑	❑	artificial joint replacement
❑	❑	tuberculosis	❑	❑	stomach ulcers/acid reflux		(circle)	hip, knee, TMJ, other
❑	❑	sinus issues	❑	❑	kidney disease	❑	❑	cancer-type/date of diagnosis
❑	❑	diabetes: type 1 / type 2	❑	❑	liver disease			_____
❑	❑	jaundice	❑	❑	drug/alcohol dependency			DDS Review: _____

Do you have any disease, condition, or illness not listed above? Please specify:

_____

Dental History

When was the last time you saw a dentist? _____

Have you ever had a bad experience at the dentist? _____

How often do you brush and floss your teeth? _____

Have you had your wisdom teeth removed? If so, when? _____

Have you ever had local anesthetic (freezing)? ___Yes ___No Any complications? _____

Have you had orthodontic treatment (braces)? If yes, include date of completion. _____

Have you ever had any type of jaw or facial surgery? ___Yes ___No _____

Do you wear a grinding appliance or nightguard? _____

Do you have a history of jaw pain? _____

Do you suffer from facial pain, fibromyalgia or trigeminal neuralgia? _____

How would you rate your smile on a scale of 1 to 10? _____

In case of emergency contact: Name _____

Phone (H) _____ (W) _____

Relationship _____

The above medical and dental history is correct and consent for treatment is hereby given.

_____ _____

Patient, Parent or Guardian Date

OFFICE USE ONLY Medical Update

Date	Same	Change	Details	Initial
_____	❑	❑	_____	_____
_____	❑	❑	_____	_____
_____	❑	❑	_____	_____
_____	❑	❑	_____	_____
_____	❑	❑	_____	_____
_____	❑	❑	_____	_____
_____	❑	❑	_____	_____
_____	❑	❑	_____	_____
_____	❑	❑	_____	_____