HEALTH HISTORY FORM
PATIENT INFORMATION

PATIENT INFORMAITON

Patient's Last name (Apellido del paciente):_____

Patient's First name (Nombre del paciente):_____

Patient's Middle (Segundo Nombre) :_____

Preferred name (Nombre preferido):_____

Gender: (Género): Male ☐ Female ☐ single/soltero ☐ married/casado ☐ child/niño ☐

Date of Birth (Fecha de nacimiento): _____ Age (Edad) :_____SS #: _____

Email (Correo electronico):_____

Occupation (Ocupación):_____Employer(Empleador):_____

Cell (Celular):_____Home phone (teléfono de casa):_____

Preferred contact method (Método preferido de contacto): Home/ Casa ☐ cell/cellular ☐ Email/correo electrónico ☐

Home address:_____

(La dirección de la casa) Street Address (dirección) City (Ciudad) State (Estado) Zip (Código Postal)

Billing Address (if different):_____

Dirección de facturación : Street Address (dirección) City (Ciudad) State (Estado) Zip (Código Postal)

Driver license number and state (Número de licencia de conducir y el estado):_____

Emergency contact name(Nombre de la persona en caso de emergencia):_____

phone (teléfono):_____ Relation(Relación):_____

Responsible Party (Persona Responsable):_____Relation to Pt(Relación con el Paciente):_____

Date of Birth (Fecha de nacimiento): SSN#

How did you find about our Practice? ____ Phone book ____ Flyer ____ Employer ____ Friend ____ Insurance ____ Others ____

INSURANCE INFORMATION

Primary Dental Insurance (Seguro Dental Primario)

Policy(Numero de Polisa) #_____Groups (Grupos) #:_____

Secondary Dental Insurance (Seguro Dental Secundario)

Policy(Numero de Polisa) #_____Groups (Grupos) #:_____

Subscriber Name (Nombre del Asegurado):_____

Date of birth(Fecha de nacimiento):_____ SS #:_____

DENTAL INFORMATION

Previous dentist's name and address(Nombre del dentista anterior y dirección):_____

Date of last dental visit (Fecha de la última visita al dentista): _____

Referred to us by (Quien lo refirio a nuestra oficina):_____

How did you hear about us? (¿Cómo se entero de nuestra oficina?)_____

Are you happy with the overall appearance of your teeth? (¿Está satisfecho con el aspecto general de sus dientes?)_____

Is there any aspect of you teeth appearance you want to change? (eg.Shape, Size, Color, Arrangement)_____

¿Hay algún aspecto de la apariencia de los dientes que desea cambiar? (Forma, tamaño, color, arreglo) _____

Are you interested in teeth whitening? (¿Está interesado en blanquear los dientes?)_____

Please Complete Both Sides

Patient Medical History

Physician: _____ Office Phone: _____ Date of last exam: _____

1. Are you under any medical treatment now? . . . . . Yes or No
2. Have you ever been hospitalized for any surgical operation or serious illness within last 5 yrs? . . Yes or No
   If yes please explain: . . . . . .
3. Are you taking any medication (s) including non-prescription medicine? . . . . . Yes or No
   If yes, please list you medication(s): . . . . . .
4. Do you use tobacco? . . . . . Yes or No
5. Have you ever taken phen phen? . . . . . Yes or No
6. Do you use controlled substances? . . . . . Yes or No
7. Are you wearing contact lenses? . . . . . Yes or No
8. Do you have or had any of the following: (Please Circle yes or no)

High blood Pressure	Y N	Low Blood Pressure	Y N	Chest Pain	Y N
Heart Attack	Y N	Cardiac Pacemaker	Y N	Heart Disease	Y N
Rheumatic Fever	Y N	Heart Murmur	Y N	Stroke	Y N
Heart Trouble	Y N	Angina	Y N	Mitral Valve Prolapse	Y N
Fainting/Seizures	Y N	Frequently Tired	Y N	Tuberculosis	Y N
Asthma	Y N	Anemia	Y N	Radiation Therapy	Y N
Easily Winded	Y N	Emphysema	Y N	Glaucoma	Y N
Epilepsy/Convulsions	Y N	Cancer	Y N	Recent Weight Lost	Y N
Leukemia	Y N	Arthritis	Y N	Respiratory problems	Y N
Diabetes	Y N	Joint replacement/implant	Y N	Swollen Ankles	Y N
Kidney Disease	Y N	Hepatitis / Jaundice	Y N	Liver Disease	Y N
AIDS or HIV infection	Y N	Stomach troubles/ulcer	Y N	Hay Fever/Allergies	Y N
Thyroid problem	Y N	Sexually transmitted Disease	Y N	Other: _____	

9. Are you allergic to or have you had any reactions to the following?

Local Anesthetics (e.g. Novocain)	Y N	Aspirin	Y N	Sedatives	Y N
Penicillin or any other antibiotics	Y N	Any metals	Y N	Latex Rubber /Powder	Y N
Sulfa Drugs	Y N	Iodine	Y N	Other: _____	Y N

10. Women ONLY:
    a) Are you pregnant or think you May be pregnant? Y N
    b) Are you Nursing? Y N
    c) Are you taking any oral Contraceptives? Y N

Authorization and Release

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 health. I authorize the dentist to release my information including diagnosis and the records to any treatment or examination rendered to my child or me during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less then the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I consent to the dental x-rays, diagnostic procedures and treatment by the dentist necessary for proper dental care.

_____ Signature of Patient / Parent / Guardian and Date

_____ Dentist's Signature and Date

FOR FUTURE VISITS/APPOINTMENTS ONLY- RECALL REVIEW UPDATE & COMMENTS:

Any change(s) in health history or Medical condition? *If Yes, Please explain:*

	Patient's signature	Date	Dentist Signature
☐ *Yes* ☐ *No*			
☐ *Yes* ☐ *No*			
☐ *Yes* ☐ *No*			