Health History

Date: ___/___/_____ Whom may we thank for referring you? _______________

Patient Information

Name: ____
Last First M.I.

S.S.#: ______-______-________

Address: ________________________________ Apt #: _______

City: ________________________________ State: ________________ZIP:_______________

Home Phone: (_____) ______________________ Cell Phone: (_____) ______________________

Email: ____

D.O.B. ___/___/_____Age: ______ Gender: Male ☐ Female ☐

Marital Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐

Employer: ____

Occupation: ________________________________ Business Phone: (_____) ____________________

Business Address: ____

City: ________________________________ State: ________________ZIP:_______________

Emergency Contact Information

Name: ________________________________ Relation: ____________________________

Primary Phone: (_____) ______________________ Alternative Phone: (_____) ______________________

Primary Dental Insurance

Same as above ☐

Name of Insured: ____________________________ D.O.B. ___/___/_____S.S.#: ______-______-________

Employer of Insured: ____

Occupation: ________________________________ Business Phone: (_____) ____________________

Business Address: ____

City: ________________________________ State: ________________ZIP:_______________

Insurance Company: ____

Group #: ______________________ Phone #: (_____) ______________________

Address: ____

City: ________________________________ State: ________________ZIP:_______________

Are you covered by another insurance carrier: Yes ☐ or No ☐

Dental History

Reason for your visit today? ____

Date of last dental visit? ___/___/_____ Date of last x-ray? ___/___/_____ How often do you brush?______Floss?______

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? **Yes** or **No**

Please describe: ____

Check if you have problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Sensitivity to cold
- ☐ Food collection between teeth
- ☐ Grinding or clinching teeth
- ☐ Loose teeth or broken filling
- ☐ Periodical treatment
- ☐ Clicking or popping jaw
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in mouth

Medical History

Physician's name: ______________________________ Phone: (_____) ____________________

Date of last visit: ___/___/_____ Have you had any serious illnesses or operations? **Yes** or **No**

If yes, describe: ____

Are you currently under physician care? **Yes** or **No** Describe:______________________________

Women Only:

Are you pregnant? **Yes** or **No** Due Date: ___/___/_____ Nursing: **Yes** or **No** Taking birth control: **Yes** or **No**

Check if you have had any of the following:

- ☐ Artificial joints
- ☐ Asthma
- ☐ Back problems
- ☐ Blood disease
- ☐ HIV positive
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Food allergies
- ☐ Tobacco use
- ☐ Thyroid disease or malfunction
- ☐ Headaches
- ☐ Heart problems
  Describe: ______________________________
  ____
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Tuberculosis
- ☐ Ulcer/Colitis
- ☐ Material allergies
  (Latex, wool, metal chemicals)
- ☐ Psychiatric care
- ☐ Nervous problems
- ☐ Osteoporosis
- ☐ Respiratory disease
- ☐ Shingles
- ☐ Shortness of breath
- ☐ Skin rash
- ☐ Stroke
- ☐ Swelling of feet or ankles

List anything that is not on the list:____

Please list any medications you are currently taking: ______________________________

Please list any drug allergies you may have: ______________________________

Comments or concerns:____

Acknowledgement of Receipt of Notice of Privacy Policy and Authorization

I have received a copy of this office's Notice of Privacy Practice (attached at the end of this document).

The undersigned hereby authorizes **St. Louis Hills Dental Group** to take necessary x-rays, study models, photographs, and /or any other diagnostic aids deemed appropriate in making a thorough diagnosis of the patient's dental needs. I realize that if dental insurance is available, policies vary from one another depending on the service rendered some policies may pay part or none of the fees incurred. Should the account become delinquent and referred to a collection agency or an attorney, I agree to pay all reasonable collection expense, court costs, and attorney fees. Delinquent accounts shall bear interest at the maximum legal rate. I authorize **St. Louis Hills Dental Group** to release all information necessary to secure the payment for benefits.

______________________________ ______________________________ ___/___/_____

Please Print Name Signature Date