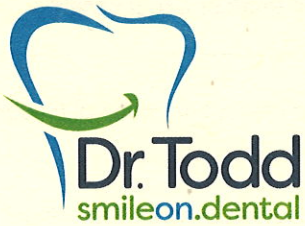
Health History Form



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PATIENT INFORMATION ***DATE***_____

Name_____ ***Date of Birth***_____

Address_____ ***City***_____ ***Zip***_____

Place of Employment _____

Social Security#_____

Cell Phone #_____ ***We use system software that will send an automated text reminding you of your appointment.*** ***Email***_____

Work#_____ ***Home#***_____

Dental insurance provider name_____ ***Group#***_____

SPOUSE OR DEPENDENT INFORMATION

Name_____ ***Date of Birth***_____

Place of Employment_____

Cell Phone #_____

Work#_____ ***Social Security#***_____

Dental insurance provider name_____ ***Group#***_____

I hereby certify that the foregoing information is accurate, and the undersigned hereby authorizes Dr. Todd E. Paczewski to perform any and all forms of treatment, medication and therapy that may be indicated in connection with my patient, and further authorizes and consents that the doctor so choose and employ such assistance as he deems fit.

_____ _____

Patient's Signature ***Date***

_____ _____

Guardians Signature ***Date***

*****PLEASE COMPLETE PERTINENT HEALTH INFORMATION ON REVERSE SIDE*****

Are you allergic or have had adverse reactions to:

Penicillin	**Yes □ No □**
Local Anesthetic	**Yes □ No □**
Latex	**Yes □ No □**

Are you taking any of the following?

Antibiotics	**Yes □ No □**
Blood thinners	**Yes □ No □**
Antidepressants	**Yes □ No □**
Cortisone (steroids)	**Yes □ No □**
Blood Pressure meds	**Yes □ No □**
Tranquilizers	**Yes □ No □**
Insulin	**Yes □ No □**
Heart medication	**Yes □ No □**

Any other medications please list

_____

_____

Women: Are you pregnant or think you could be? **Yes □ No □**

Have you had surgery in the last six months? **Yes □ No □**
so please list the condition(s) treated:

_____

_____

Please indicate any history of the following:

Artificial Heart Valves
Yes □ No □

Implants or Prosthesis
Yes □ No □

History of heart attack
Yes □ No □

Diabetic
Yes □ No □

Tobacco use
Yes □ No □

Arthritis
Yes □ No □

Inflammatory RH
Yes □ No □

High Blood Pressure
Yes □ No □

Any bleeding conditions or disorders
Yes □ No □

Fainting Spells or seizures
Yes □ No □

Tumors or growths
Yes □ No □

Aids or HIV
Yes □ No □

Venereal Disease
Yes □ No □

Hepatitis or any liver condition
Yes □ No □

Kidney problems
Yes □ No □

Depression
Yes □ No □

Are you aware that your insurance may offer you additional dental wellness benefits for a reported medical condition? Would you like to learn what benefits are offered to you? _____

What are your current dental concerns:

_____

_____

_____

Have you ever had a cracked tooth or a root canal?

_____

Are you aware of any past or present periodontal ("gum") problems? _____

Have you ever had a deep cleaning before? If so when?

_____

Have you noticed receding gum tissue; making your teeth appear longer? _____

Are your teeth sensitive? If so when did you notice it?

_____

Do you experience bleeding while brushing or flossing?

_____

Do you think you have bad breath? _____

Would you like more information on making your teeth whiter? _____

Are there any old fillings, crowns or bridges that are not esthetic? _____

Is there anything else regarding your dental health, appearance or comfort that you would like to share or discuss with the doctor?

_____

_____

When we call is there anyone on your behalf that we are allowed to talk to about your account / appointments / treatment if you're not available?

_____

_____

For Children:

Does your child use a toothpaste with fluoride in it?

_____

Do you help your child with brushing/flossing?

_____

Does your child complain about mouth pain?

_____