

Adult Pre-Clinical History

Account Number _____

Today's Date _____

DENTAL HEALTH ASSOCIATES



Trusted Care Since 1972

ABOUT YOU

Name: _____ Female Male

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Social Security #: _____

Birth Date: ____/____/____ Marital Status: Single Married Widowed

E-mail Address: _____

Name of spouse: _____

Who can we thank for referring you? _____

EMERGENCY INFORMATION

Person to Contact: _____

Relationship: _____

Phone: _____

DENTAL INSURANCE INFORMATION

Primary Insurance company name: _____

Subscriber: _____

Subscriber's birth date: _____ Relationship to Patient _____

ID number: _____

Social Security number: _____

Employer: _____

Secondary Insurance company name: _____

Subscriber: _____

Subscriber's birth date: _____ Relationship to Patient _____

ID number: _____

Social Security number: _____

Subscriber employer: _____

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges, to the extent permitted under applicable law. I authorize release of information relating to this claim. I also authorize payment of dental benefits, otherwise payable to me, to be paid directly to Dental Health Associates. Initials: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions:

Dental History

How do you feel your overall dental health is? _____
Do you have fear of dental procedures? Yes No
How do you feel about your smile and the look of your teeth: _____

What is the main reason for your visit today?

Tooth pain Yes No
I need a check-up Yes No
Cleaning Yes No
Orthodontics (braces) Yes No
Whitening Yes No
Cosmetic dentistry Yes No
Sedation dentistry Yes No
Other Yes No

Are you under a physician's care now? If yes, please provide physician's name and phone number. Yes No If yes _____
Have you been hospitalized or had a major operation in the last 2 years? Yes No If yes _____
Have you ever had a serious head or neck injury? Yes No If yes _____
Are you taking any medications, pills or drugs? Yes No If yes _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes _____
Do you use tobacco? Yes No If yes _____
Do you use any controlled substances? Yes No If yes _____

Women: Are you . . .

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin/Other Antibiotics Codeine/Other Narcotics Acrylic
 Metal Latex Sulfa Drugs Local Anesthetics
 Shellfish, Iodine or Red Wine

If so, list your allergies not listed above. _____

Comments: _____

Do you need to pre-medicate w/antibiotics prior to dental treatment Yes No If yes _____

Have you ever had any serious illness not listed Yes No If yes _____

Do you have, or have you had in the last 5 years, any of the following?

| | | | | | | | |
|---------------------------|--|----------------------------|--|-----------------------|--|------------------------|--|
| AIDS/HIV Positive | <input type="radio"/> Yes <input type="radio"/> No | Hemophilia | <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatments | <input type="radio"/> Yes <input type="radio"/> No | Alzheimer's Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Diabetes | <input type="radio"/> Yes <input type="radio"/> No | Acid Reflux | <input type="radio"/> Yes <input type="radio"/> No | Anaphylaxis | <input type="radio"/> Yes <input type="radio"/> No | Drug Addiction | <input type="radio"/> Yes <input type="radio"/> No |
| Renal Dialysis | <input type="radio"/> Yes <input type="radio"/> No | Anemia | <input type="radio"/> Yes <input type="radio"/> No | Easily Winded | <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever | <input type="radio"/> Yes <input type="radio"/> No |
| Angina | <input type="radio"/> Yes <input type="radio"/> No | Emphysema | <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure | <input type="radio"/> Yes <input type="radio"/> No | Rheumatism | <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout | <input type="radio"/> Yes <input type="radio"/> No | Epilepsy or Seizures | <input type="radio"/> Yes <input type="radio"/> No | High Cholesterol | <input type="radio"/> Yes <input type="radio"/> No | Scarlet Fever | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve | <input type="radio"/> Yes <input type="radio"/> No | Excessive Bleeding | <input type="radio"/> Yes <input type="radio"/> No | Hives or Rash | <input type="radio"/> Yes <input type="radio"/> No | Shingles | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joint | <input type="radio"/> Yes <input type="radio"/> No | Excessive Thirst | <input type="radio"/> Yes <input type="radio"/> No | Hypoglycemia | <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Asthma | <input type="radio"/> Yes <input type="radio"/> No | Fainting | <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat | <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble | <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease | <input type="radio"/> Yes <input type="radio"/> No | Frequent Cough | <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems | <input type="radio"/> Yes <input type="radio"/> No | Blood Transfusion | <input type="radio"/> Yes <input type="radio"/> No |
| Leukemia | <input type="radio"/> Yes <input type="radio"/> No | Stomach/Intestinal Disease | <input type="radio"/> Yes <input type="radio"/> No | Breathing Problems | <input type="radio"/> Yes <input type="radio"/> No | Liver Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Stroke | <input type="radio"/> Yes <input type="radio"/> No | Bruise Easily | <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure | <input type="radio"/> Yes <input type="radio"/> No | Swelling of Lmbs | <input type="radio"/> Yes <input type="radio"/> No |
| Cancer | <input type="radio"/> Yes <input type="radio"/> No | Glaucoma | <input type="radio"/> Yes <input type="radio"/> No | Lung Disease | <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy | <input type="radio"/> Yes <input type="radio"/> No | Seasonal Allergies | <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse | <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis | <input type="radio"/> Yes <input type="radio"/> No |
| Chest Pains | <input type="radio"/> Yes <input type="radio"/> No | Heart Attack/Failure | <input type="radio"/> Yes <input type="radio"/> No | Osteoporosis | <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis | <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores/Fever | <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur | <input type="radio"/> Yes <input type="radio"/> No | Pain in Jaw Joints | <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths | <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disorder | <input type="radio"/> Yes <input type="radio"/> No | Heart Pacemaker | <input type="radio"/> Yes <input type="radio"/> No | Ulcers | <input type="radio"/> Yes <input type="radio"/> No | Convulsions | <input type="radio"/> Yes <input type="radio"/> No |
| Heart Trouble/Disease | <input type="radio"/> Yes <input type="radio"/> No | Psychiatric Care | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis A, B or C | <input type="radio"/> Yes <input type="radio"/> No | Bacterial Endocarditis | <input type="radio"/> Yes <input type="radio"/> No |
| Sleep Apnea | <input type="radio"/> Yes <input type="radio"/> No | | | | | | |

The information I have given is true and accurate to the best of my knowledge.

X _____

Date _____