ORLANDO HEALTH HISTORY

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

ABOUT YOU

Today's Date: ____________________

E-mail: ____________________

Name: ____________________
LAST FIRST Mi Mr Mrs Miss Dr

I preferred to be called: ____________________

Birthdate: ___/___/___ Age: ___ SS#: ____________________

Home Address: ____________________
APT / CONDO #

____
CITY STATE ZIP

○ Single ○ Married ○ Divorced ○ Widowed ○ Separated

Hm #: (___) __________ Pager/Cell #: __________

Wk #: (___) __________ Ext: ___ DL #: __________

Employer: ____________________

Employer's Address: ____________________

How long there? ______ Occupation: ____________________

Where & when are best times to reach you? ____________________

Whom may we Thank for referring you? ____________________

Other family members seen by us: ____________________

Previous/Present Dentist: ____________________

Dentist Phone #: (___) __________ Last Visit Date: __________

SPOUSE INFORMATION

His/Her Name: ____________________

Employer: ____________________

Wk #: (___) __________ Ext: ___ DL #: __________

Birthdate: ___/___/___ Age: ___ SS #: ____________________

Person Responsible for Account:

Wk #: (___) __________ Ext: ______ Hm #: (___) __________

Billing Address: ____________________

Relationship: __________ SS #: __________

Employer: __________ DL #: __________

INSURANCE

PRIMARY INSURANCE

Dental Coverage? ○ Yes ○ No

Insurance Co. Name: ____________________

Insurance Co. Address: ____________________

Insurance Co. Phone #: (___) ____________________

Group # (Plan, Local or Policy #): ____________________

Insured's Name: __________ Relation: __________

Insured's Birthdate: ___/___/___ Insured's SS#: __________

Insured's Employer: ____________________

Employer's Address: ____________________

SECONDARY INSURANCE

Dental Coverage: ____________________

Insurance Co. Name: ____________________

Insurance Co. Address: ____________________

Insurance Co. Phone #: (___) ____________________

Group # (Plan, Local or Policy #): ____________________

Insured's Name: __________ Relation: __________

Insured's Birthdate: ___/___/___ Insured's SS#: __________

Insured's Employer: ____________________

Employer's Address: ____________________

NEIGHBOR OR RELATIVE NOT LIVING WITH YOU

His/Her Name: ____________________

Wk #: (___) __________ Hm #: (___) __________

Address: ____________________
APT / CONDO #

____
CITY STATE ZIP

MEDICAL HISTORY

Do you have a personal physician? ○ Yes ○ No

Physician's Name: ____________________

Phone #: (___) __________ Date of last visit: __________

Are you currently under the care of a physician? ○ Yes ○ No

Please explain: ____________________

MEDICAL HISTORY (continued)

Your current physical health is: ○ Good ○ Fair ○ Poor

Do you smoke or use tobacco in any other form? ○ Yes ○ No

Have you had any metal rods, pins or implants? ○ Yes ○ No

Are you taking any prescription / over-the-counter or herbal supplement drugs? ○ Yes ○ No

Please list each one: ____________________

____

For Women: Are you taking birth control pills? ○ Yes ○ No

Are you pregnant? ○ Yes ○ No Week #: ______

Are you nursing? ○ Yes ○ No

Have you ever had any of the following diseases or medical problems?

Y	N	Abnormal Bleeding / Hemophilia	Y	N	Herpes / Fever Blisters
Y	N	Alcohol / Drug Abuse	Y	N	High Blood Pressure
Y	N	Anemia	Y	N	Hospitalized for Any Reason
Y	N	Arthritis	Y	N	Kidney Problems
Y	N	Artificial Bones / Joints / Valves	Y	N	Liver Disease
Y	N	Asthma	Y	N	Low Blood Pressure
Y	N	Blood Transfusion	Y	N	Lupus
Y	N	Cancer / Chemotherapy	Y	N	Mitral Valve Prolapse
Y	N	Colitis	Y	N	Pacemaker
Y	N	Congenital Heart Defect	Y	N	Psychiatric Problems
Y	N	Diabetes	Y	N	Radiation Treatment
Y	N	Difficulty Breathing	Y	N	Rheumatic / Scarlet Fever
Y	N	Emphysema	Y	N	Seizures
Y	N	Epilepsy	Y	N	Shingles
Y	N	Fainting Spells	Y	N	Sickle Cell Disease / Trails
Y	N	Frequent Headaches	Y	N	Sinus Problems
Y	N	Glaucoma	Y	N	Stroke
Y	N	Hay Fever	Y	N	Thyroid Problems
Y	N	Heart Attack / Surgery	Y	N	Tuberculosis (TB)
Y	N	Heart Murmur	Y	N	Ulcers
Y	N	Hepatitis	Y	N	Venereal Disease

Anything that you would like to discuss with the dentist in private? ○ Yes ○ No

Please list any serious medical condition(s) that you have ever had:

____

____

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Erythromycin	Y	N	Penicillin
Y	N	Codeine	Y	N	Jewelry / Metals	Y	N	Tetracycline
Y	N	Dental Anesthetics	Y	N	Latex	Y	N	Other

Please list any other drugs / materials that you are allergic to: ____________________

____

INSURANCE

Why have you come to the dentist today? ____________________

____

Have you ever taken Phen-Phen? Also known as Redux & Pondimin.

If so, when ____________________ ○ Yes ○ No

Do you require antibiotics before dental treatment? ○ Yes ○ No

Are you currently in pain? ○ Yes ○ No

Have you ever had a serious / difficult problem associated with any previous dental work? ○ Yes ○ No

Have you ever had gum treatment? ○ Yes ○ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ○ Yes ○ No

Your current dental health is: ○ Good ○ Fair ○ Poor

Do you like your smile? ○ Y ○ N Do your gums bleed? ○ Y ○ N

How many times a week do you floss? ______ a day do you brush? ______

Type of bristles? ○ Hard ○ Medium ○ Soft

How long do you use a toothbrush before replacing it? ______

Are your teeth sensitive to heat, cold, or anything else? ______

Have you lost any teeth? ○ Yes ○ No If yes, why? ______

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

SIGNATURE ____________________ DATE ______

Payment is due in full at the time of treatment
unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information including the diagnosis and records of treatment or examination rendered, to my insurance company.

SIGNATURE ____________________ DATE ______

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient herein. Initials: Date:

Doctor's Comments: ____________________

____

MEDICAL HISTORY UPDATE

I have read my medical history dated ______ and confirmed that it states past and present medical conditions. SIGNATURE ______ DATE ______

I have read my medical history dated ______ and confirmed that it states past and present medical conditions. SIGNATURE ______ DATE ______

I have read my medical history dated ______ and confirmed that it states past and present medical conditions. SIGNATURE ______ DATE ______