Patient Health History

Patient ID #

Name _____
(first name) (middle name (last name)

Sex: ___M___F Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____

☐married ☐single ☐other Email Address: _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Emergency Contact Name & Phone Number_____

Race: ____African American ____Asian American ____Caucasian/White ____Hispanic ____Other

Name of Family Physician: _____ City: _____ State: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

- What is your reason for today's visit?_____

_____

- Have you received treatment in our office previously? YES NO If so, when? _____
- How did you learn about our affiliated dental practice providing Affordable Dentures? (circle one)

  1. Magazine 2. Newspaper 3. Radio 4. Billboards/Sign 5. Brochure/Mail

  6. Television 7. Newspaper 8. Friend/Relative 9. Internet/Web Site 10. Other Doctor

  11. Outside Agency

- Did you call our toll-free information service (1-800-DENTURE)? YES NO
- May we provide your name to denture product companies who may wish to send you information on their products? YES NO
- May we contact you with information about special offers and new services we may offer at Affordable Dentures? YES NO If answer is YES, what is the best way to contact you?

(Please circle all methods of communication that you prefer below.)

Mail **Phone** **Email**

Do you have commercial dental insurance? YES NO Name of Insurance: _____

If YES, we will provide you with a special statement of services for use when you submit your claim.

YES NO Are you currently wearing dentures? If YES, when did you receive your last dentures?_____

YES NO Do you use denture adhesives, paste, or powder? If so, please describe_____

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CRITICAL HEALTH HISTORY QUESTIONS:

YES NO Have you ever had CANCER?
IF YES, where is/was the cancer? _____
YES NO Have you ever had RADIATION TREATMENT for cancer?
YES NO Have you ever had CHEMOTHERAPY treatment for cancer?
YES NO Have you ever been diagnosed with OSTEOPOROSIS (bone loss)?
YES NO Have you ever taken prescription medication for OSTEOPOROSIS?
For example, FOSAMAX? Please specify:_____
If YES, was/is the medication an INJECTION or ORAL PILL? (Circle One)
If YES, what was the date of the last time you took the medication?_____
YES NO Do you take any BLOOD THINNER medication?
IF YES, please specify:_____
YES NO Have you ever had a heart attack?
IF YES, when? _____
YES NO Have you ever had a stroke?
IF YES, when? _____
YES NO Are you allergic to LATEX? Please specify:_____
YES NO Are you allergic to any medication? Please specify:_____

Please list any medications you currently take (including Herbal Supplements): _____
_____
_____

BLOOD PRESSURE (to be filled out by your dental assistant): _____ / _____ _____ / _____

HAVE YOU EVER HAD...

YES NO Teeth extracted? If YES, when: _____
Any problems? _____
YES NO Bleeding problems?
YES NO Bad reaction to anesthesia?
YES NO Heart Problems? Please specify:_____
YES NO Prosthetic (false) joints, knee, hip, or valves?
Please specify:_____
YES NO Circulatory problems?
YES NO Tuberculosis or other chronic ailments?
For example, Chronic Obstructive Pulmonary Disease or C.O.P.D.
YES NO Hepatitis or Liver Disease?
YES NO Diabetes or kidney failure?
YES NO Rheumatic fever or heart murmur?
YES NO High or Low Blood Pressure? Please circle and/or specify:_____
YES NO Immune system disorder or infection, including HIV?
YES NO Fainting spells or seizures?
YES NO Do you take ASPIRIN daily?
YES NO Are you taking birth control pills or using other hormonal birth control method?
For example, NORPLANT? Please specify:_____
YES NO Are you pregnant or nursing?
YES NO Do you smoke or use tobacco products?
YES NO Do you use illegal drugs? (For example, MARIJUANA or COCAINE)
YES NO Do you have any sores in your mouth?

To the best of my knowledge the above questions have been answered accurately. I understand that the fee for dentures, extractions, and other services must be paid on the first visit I am seen by the dentist.
PATIENT SIGNATURE:_____DATE:_____