

DENTAL GROUP NEW YORK

PATIENT INFORMATION - Health History Form

*Welcome to our office! To assist us in serving you, please complete the following confidential form.
The information provided is important to your dental health.*

Patient's name _____		Birth date _____	
If minor, parents names _____		Mobile phone _____	
Work phone _____		Referred By _____	
EMAIL _____			
Mailing address _____		City _____	State _____ Zip _____
Employer _____		Occupation _____	
Spouse's name _____		Spouse's employer _____ <input type="checkbox"/> Unmarried	
BILLING, CREDIT, AND INSURANCE INFORMATION: <input type="checkbox"/> Not covered by dental insurance			
Your Social Security number: _____		Dental Insurance Co. _____ Group number _____	
Covered by spouse's insurance? <input type="checkbox"/> yes <input type="checkbox"/> no			
Spouse's dental insurance company _____		Group number _____	
Spouse's birthday _____		Social Security number _____	

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- Cancer or tumor
- Heart ailment or angina
- Heart murmur, mitral valve prolapse, heart defect
- Rheumatic fever or rheumatic heart disease
- Artificial joint or valve
- High or low blood pressure
- Pacemaker
- Tuberculosis or other lung problems
- Kidney disease
- Hepatitis or other liver disease
- Alcoholism
- Blood transfusion
- Diabetes
- Neurologic condition
- Epilepsy, seizures, or fainting spells
- Emotional condition
- Arthritis
- Herpes or cold sores
- AIDS or HIV positive
- Migraine headaches or frequent headaches
- Anemia or blood disorders
- Abnormal bleeding after extractions, surgery, or trauma
- Hayfever or sinus trouble
- Allergies or hives
- Asthma

Do you smoke or use chewing tobacco? yes no

Are you allergic to, or have you reacted adversely to any of the following?

- Latex materials
- Penicillin or other antibiotics
- Local anesthetics ("Novocain")
- Codeine or other narcotics
- Sulfa drugs
- Barbiturates, sedatives, or sleeping pills
- Aspirin
- Other: _____

Are you taking any of the following?

- Aspirin
- Anticoagulants (blood thinners)
- Antibiotics or sulfa drugs
- High blood pressure medicine
- Antidepressants or tranquilizers
- Insulin, Orinase, or other diabetes drug
- Nitroglycerin
- Cortisone or other steroids
- Osteoporosis (bone density) medicine
- Other: _____

Women:

- May be pregnant
Expected delivery date: _____
- Taking hormones or contraceptives

Name of your physician: _____

Do you have any disease, condition, or problem not listed above? _____

Please add anything else you would like us to know about: _____

Signature of patient (or parent) _____ Date _____