Patient Health History

DATE: ________________________

Patient Information

First: ______________________ Middle: __________ Last: ______________________
Street: ______________________ City: ______________ State: ________ Zip: ____________
Home Phone: ______________________ Work Phone: ______________________
Cell Phone: ______________________ Email: ______________________
Patient Social Security #: ______________ Patient Date of Birth: ______________ Sex: M F
Driver's License #: ______________________
Emergency Contact: ______________________ Phone: ______________________
Employer: ______________________ Occupation: ______________________
Employer's Address: ______________________ City: ______________ State: ________ Zip: ____________
If Student, name of School/College: ______________ City: ______________ State: ________ Zip: ____________

How did you hear about Hudec Dental?

☐ Insurance Company ☐ Neighborhood ☐ Yellow Pages ☐ Referral (name)
☐ Mail ☐ TV ☐ Internet ______________________

If the person responsible for this patient's account is different from the patient or if this patient is a minor, the responsible party must fill out the section below. Otherwise, please skip to the section titled "Insurance Information".

Name of responsible party: ______________ Relationship to Patient: ______________________
Mailing Address: ______________________ City: ______________ State: ________ Zip: ____________
Sex: M F Age: ________ Birth Date: ____________ Single Married Widowed Separated Divorced SS#: ____________
Home Phone: ______________________ Work Phone: ______________________
Occupation: ______________________ Employer: ______________________
Employer Address: ______________________ Occupation: ______________________
Emergency Contact: ______________________ Phone: ______________________
Employer: ______________________ Occupation: ______________________
Employer's Address: ______________________ City: ______________ State: ________ Zip: ____________

Insurance Information

Primary Dental Insurance

Policy Holder's Name: ______________________ Relationship to Patient: SS#: DOB: ________
Employer: ______________________ Employer Address: ______________________ State: ________
Insurance Co.: ______________________ Group #: ______________ Address: ______________
Home Phone: ______________________ Work Phone: ______________________

Secondary Dental Insurance

Policy Holder's Name: ______________________ Relationship to Patient: SS#: DOB: ________
Employer: ______________________ Employer Address: ______________________ State: ________
Insurance Co.: ______________________ Group #: ______________ Address: ______________
Home Phone: ______________________ Work Phone: ______________________

Health History

Answers to the following questions are for our records only and will be considered confidential.

Place a mark, yes or no, to indicate if you have had any of the following:

Condition			Condition			Condition		
Heart Disease or Attack	Yes	No	Shortness of Breath	Yes	No	Alcoholism	Yes	No
Angina Pectoris	Yes	No	Ulcers	Yes	No	Herpes	Yes	No
Heart Problems	Yes	No	Mental Retardation	Yes	No	Glaucoma	Yes	No
Liver Disease	Yes	No	Emphysema	Yes	No	*Steroid Treatment	Yes	No
High Blood Pressure	Yes	No	Fainting or Dizzy Spells	Yes	No	Arthritis	Yes	No
*Heart Murmur	Yes	No	Epilepsy or Seizures	Yes	No	Birth Defects	Yes	No
*Rheumatic Fever	Yes	No	Persistent Cough	Yes	No	HIV Positive, ARC, AIDS	Yes	No
Psychiatric Treatment	Yes	No	Tuberculosis (TB)	Yes	No	Hay Fever	Yes	No
Sickle Cell Disease	Yes	No	Asthma	Yes	No	Use of Tobacco Products	Yes	No
Sinus Trouble	Yes	No	*Congenital Heart Problems	Yes	No	Bruise Easily	Yes	No
*Artificial Joints	Yes	No	Hepatitis A (Infectious)	Yes	No	Jaundice	Yes	No
Thyroid Disease	Yes	No	Hepatitis B (Serum)	Yes	No	Kidney Trouble	Yes	No
Anemia	Yes	No	Hepatitis C or Other	Yes	No	Human Papilloma Virus/HPV	Yes	No
Blood Transfusion	Yes	No	Heart Pacemaker	Yes	No	Hemophilia	Yes	No
*Any Type of Transplant	Yes	No	Stroke	Yes	No	Diabetes	Yes	No
*Mitral Valve Prolapse	Yes	No	Drug Addiction	Yes	No	Chemotherapy/Radiation	Yes	No
Hives or Skin Rash	Yes	No	Cold Sores	Yes	No	Cancer, type:____________	Yes	No
Scarlet Fever	Yes	No	COPD (Chronic Obstructive Pulmonary Disorder)	Yes	No			

* Antibiotic pre-medication may be required prior to your appointment.

ALLERGIES

Aspirin	Local Anesthetic	Barbituates
Penicillin	Codeine	Sulfa
Iodine	Metals	Latex

Other: _________________

MEDICATIONS

Please list medications you are currently taking:

____

____

Pharmacy: ______________________________

Do you have existing dentures Yes No Age _______ Upper/Lower

Do you have existing partials Yes No Age _______ Upper/Lower

1. Have you or any member of your family been seen by us before? Yes No
   If yes, which family member(s)? ____
2. Date of last physical examination: ____________________ Physician's name: __________________________________
3. Previous dentist's name: ____________________________ Date of last dental x-rays: ____________________________
4. Are you having pain or discomfort at this time? Yes No
5. Do you have a history of trauma to your jaw? Yes No
6. Do you clench or grind your teeth? Yes No
7. Have you been a patient in the hospital during the past two years? Yes No
8. Have you taken any medications or drugs in the past two years? Yes No
9. Do you have any sores, lumps or growths in or near your mouth? Yes No
10. Have you ever had any excessive bleeding requiring special treatment? Yes No
11. Have you ever been told you have gum problems? Yes No
12. Have you ever needed to see a periodontist? Yes No
13. Is there anything you would like to change about the way your smile looks? straighter whiter
14. Do you currently have any of the following? swelling bleeding gums loose teeth bad breath
15. Is there anything related to your medical or dental history that you have not indicated above? Yes No
    If yes, please explain: ____

WOMEN: Are you pregnant now? Yes No If yes, what is your due date? _______________________

Are you currently breast feeding? Yes No

Are you taking oral contraceptives? Yes No

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of parent or guardian: ____ Date: _____________________________