HEALTH HISTORY

Patient Name _____ Date of Birth _____ Date _____

Answer all questions by circling Yes (Y) or No (N)

1. Are you in good health? Y N
2. Has there been any change in your general health in the past year? Y N
3. Have you **ever** had any serious illnesses, operations or hospitalizations? If so please describe
_____ Y N
_____
_____
_____
4. Date of last physical exam _____
5. Are you now under a physician's care for a particular problem? Y N
6. Height _____ Weight _____
7. **DO YOU HAVE OR HAVE YOU EVER HAD:**
A. Rheumatic Fever or Rheumatic Heart Disease? Y N
B. Congenital Heart Disease? Y N
C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker)? Y N
D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of breath, Chest Pain, Severe Cough)? Y N
E. Seizures, Convulsions, Epilepsy, fainting or Dizziness? Y N
F. Liver Disease (Jaundice, Hepatitis)? Y N
G. Bleeding disorder, Anemia, Bleeding tendency, Blood transfusion? Do you bruise easily? Y N
H. Kidney Disease? Y N
I. Diabetes? Y N
J. Thyroid Disease? Y N
K. Arthritis? Y N
L. Stomach Ulcers or Colitis? Y N
M. Glaucoma? Y N
N. Osteoporosis? Y N
O. Implants placed anywhere in your body (Heart valve, Pacemaker, Hip, Knee)? Y N
P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? Y N
Q. Radiation (X-ray) treatment for cancer? Y N
R. Sinus or nasal problems? Y N
S. Any disease, drug or transplant operation that has depressed your immune system? Y N
8. **ARE YOU USING ANY OF THE FOLLOWING:**
A. Antibiotic Y N
B. Anticoagulants (Blood thinners) Y N
C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen... Y N
D. High blood pressure medication Y N
E. Steroids (Cortisone, etc.) Y N
F. Tranquilizers Y N

All responses are kept confidential

G. Insulin or Oral Anti-Diabetic drugs? Y N
H. Digitalis, Inderal, Nitroglycerin or other heart drug? Y N
I. Are you taking or **have you ever taken** Bisphosphonates for osteoporosis, multiple myeloma or other cancers (Fosamax, Antonel, Boniva, Aredia, Zometa)? Y N
J. Please list any and all medications taken, including prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins or minerals:
_____
_____
_____
_____
9. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
A. Local Anesthsia (Novocain, etc.) Y N
B. Penicillin or antibiotics Y N
C. Sedatives, Barbiturates Y N
D. Aspirin or Ibuprofen Y N
E. Codeine or other pain killers Y N
F. Latex or Rubber Products Y N
G. Other allergies or reactions Please list
_____
_____
_____
_____
10. Do you smoke or chew tobacco? Y N
How much per day? _____
11. Is there any past history of Alcohol or chemical dependency or Emotional disorder that may affect the care we provide you? Y N
12. Have you had any serious problems associated with any previous dental treatment? Y N
13. Have you or an immediate family member had any problem associated with intravenous anesthesia? Y N
14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? Y N
15. Do you wish to speak with the doctor privately? Y N
16. **FOR WOMEN ONLY**
A. Are you pregnant, or **is there any chance** you might be pregnant? Y N
B. Are you nursing? Y N
C. **If you are using Oral Contraceptives,** it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidence.

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Health History with my doctor. As well as authorize payment of the dental benefits otherwise payable to me, directly to the below named dentist. I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

_____ _____ _____
Patient/Guardian Signature Doctor's Initials Date

Treating Doctor: Jeremy W. Cull DDS **Doctor Notes:**
_____
_____
_____
_____

PATIENT INFORMATION (Please Print)

Title: _____ First Name: _____ MI: ____ Last Name: _____

Birthdate: _____ Soc. Sec.: _____ Gender: Male Female

Address: _____ Apt./Suite: _____

City: _____ State: _____ Zip Code: _____

Phones: Home: _____ Work: _____ Ext: _____

Mobile: ( ) - _____ Fax: _____ Email: _____

Employer: _____ Phone: ( ) - _____ Occupation: _____

Referred By: _____ General Dentist: _____

Have you been seen in this practice before today? Yes No

PERSON RESPONSIBLE FOR ACCOUNT (if other than patient)

Title: _____ First Name: _____ MI: ____ Last Name: _____

Relationship to Patient: ☐ patient ☐ spouse ☐ child ☐ other - please specify _____ Soc. Sec.: _____

Address: _____ Apt./Suite: _____

City: _____ State: _____ Zip Code: _____

Phones: Home: _____ Work: _____ Ext: _____

Mobile: ( ) - _____ Fax: _____ Email: _____

Employer: _____ Phone: ( ) - _____ Occupation: _____

DENTAL INSURANCE INFORMATION

Primary Insurance

Ins. Co. _____

Group #: _____ Phone: _____

Employer: _____

Employee (if other than patient)

Name: _____ _____

Birthdate: _____ Soc. Sec.: _____

Subscriber #: _____ Sex: Male Female

Secondary Insurance

Ins. Co. _____

Group #: _____ Phone: _____

Employer: _____

Employee (if other than patient)

Name: _____ _____

Birthdate: _____ Soc. Sec.: _____

Subscriber #: _____ Sex: Male Female

_____ _____ _____ _____

Signature (parent or guardian if patient is a minor) Date Signature of authorized representative of Casa Grande Oral Maxillofacial Surgery Date