

Personal Information – Health History

Center For Advanced Dentistry
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NAME _____ Birthdate _____ Social Security no. _____

MAILING ADDRESS _____

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

HOW OR WHO REFERED YOU TO OUR OFFICE? _____

PHONES: Work: _____ Home: _____ FAX: _____
 Cell: _____ pager: _____ email: _____

OCCUPATION: _____ EMPLOYER & address _____
 Spouse's OCCUPATION _____ EMPLOYER & address _____

ACCOUNT RESPONSIBILITY if someone other than yourself: NAME: _____
 Their Social Security No. _____ Birthdate: _____
 Mailing Address: _____ Daytime phone _____

INSURANCE: If you have dental insurance, we will provide you with receipt documentation than can be attached to your insurance company form for proper filing. You will receive a reimbursement directly for whatever you are entitled to. The most important thing for you to know is the amount of your "calendar year maximum" which you can find by calling your insurance carrier.

HEALTH HISTORY (please check if you have or had any of the following)	
<input type="checkbox"/> yes <input type="checkbox"/> no Are you in good health <input type="checkbox"/> yes <input type="checkbox"/> no Has your health changed in the last year <input type="checkbox"/> yes <input type="checkbox"/> no Chest pain, shortness of breath <input type="checkbox"/> yes <input type="checkbox"/> no Bleeding problems, bruise easily <input type="checkbox"/> yes <input type="checkbox"/> no Headaches, ringing in ears <input type="checkbox"/> yes <input type="checkbox"/> no Joint pain or stiffness, arthritis <input type="checkbox"/> yes <input type="checkbox"/> no Fainting or seizures <input type="checkbox"/> yes <input type="checkbox"/> no Heart disease, murmurs, rheumatic fever, prosthetic heart valve <input type="checkbox"/> yes <input type="checkbox"/> no Pacemaker <input type="checkbox"/> yes <input type="checkbox"/> no High Blood pressure	<input type="checkbox"/> yes <input type="checkbox"/> no TB, asthma or lung disease <input type="checkbox"/> yes <input type="checkbox"/> no Hepatitis or liver disease <input type="checkbox"/> yes <input type="checkbox"/> no Diabetes <input type="checkbox"/> yes <input type="checkbox"/> no Tumors, cancer <input type="checkbox"/> yes <input type="checkbox"/> no Radiation treatment <input type="checkbox"/> yes <input type="checkbox"/> no Psychiatric care <input type="checkbox"/> yes <input type="checkbox"/> no Kidney or bladder disease <input type="checkbox"/> yes <input type="checkbox"/> no VD, herpes <input type="checkbox"/> yes <input type="checkbox"/> no HIV positive, AIDS, ARC <input type="checkbox"/> yes <input type="checkbox"/> no Pregnant: month _____ <input type="checkbox"/> yes <input type="checkbox"/> no Birth Control Pills <input type="checkbox"/> yes <input type="checkbox"/> no Recreational drugs, smoking/ alcohol
List any and all ALLERGIES: _____	
List any and all DRUGS/MEDICATIONS you are taking: _____	
List any and all SURGERIES: _____	
<input type="checkbox"/> yes <input type="checkbox"/> no Are you being treated by a Doctor now? If yes, who? _____	

The above information is true and correct to the best of my knowledge:

PATIENT SIGNATURE: _____ DATE: _____