HEALTH HISTORY UPDATE

Patient Name_____**Phone#**_____**Cell#**_____**Work#**_____

Address_____**Email:**_____

Please List Prescription Medications & Over the Counter Medications (put purpose if you cannot remember name, such as *blood pressure pill or sinus antibiotic):*_____

_____

_____

_____

Allergies (circle): Penicillin Sulfa Codeine Acetaminophen Aspirin Ibuprofen Latex Other list)_____

Have you ever had a reaction to Epinephrine or any dental anesthetic used to get you numb? Yes No _____

Please circle YES if you have or have ever had the following conditions and circle NO if the condition does not apply to you:

AIDS or Hiv infection	Yes No	Heart Murmur	Yes No	Neurological Disorder_____	Yes No
Anemia	Yes No	Heart Attack	Yes No	Developmental Disorder_____	Yes No
Asthma	Yes No	Bypass	Yes No	Radiation Treatment	Yes No
Arthritis	Yes No	Stent	Yes No	Rheumatic Fever	Yes No
Prolong Bleeding	Yes No	Valve Replacement	Yes No	Sinus Trouble	Yes No
Cancer-type_____When?_____	Yes No	Congenital Heart Defect	Yes No	Seasonal Allergies Mild Moderate Severe	
Oral Cancer When?_____	Yes No	Cardiac Pacemaker	Yes No	Seizures/Fainting	Yes No
Chemo treatment When?_____	Yes No	Other Heart Condition_____		Severe Gag Reflux	Yes No
Premed for Dental Appointment	Yes No	High Blood Pressure	Yes No	Sexually Transmitted Disease	Yes No
Diabetes	Yes No	Low Blood Pressure	Yes No	Strokes	Yes No
Epilepsy/Convulsions	Yes No	Kidney Disease	Yes No	Thyroid Problems	Yes No
Eating Disorder	Yes No	Liver Disease	Yes No	Tuberculosis or Lung Disease	Yes No
Hepatitis Type_____	Yes No	Lung Problems	Yes No	Ulcers/Stomach Troubles	Yes No
Glaucoma	Yes No	Leukemia	Yes No	Joint Replacement	
Infectious/Contagious Disease	Yes No	Mental/ Anxiety Disorder	Yes No	What?_____When?_____	
Headaches	Yes No	Pregnant Due Date_____		What?_____When?_____	

List any other medical problems:_____ **Tobacco Products Used & Frequency:**_____

Describe ANY (not just dental) surgeries you have had in the past 5 years or since your last visit or any you believe are significant:

_____

_____

PRIMARY DENTAL INSURANCE INFORMATION (CONFIDENTIAL)

Name of Policyholder_____ Relationship to Patient_____

Policyholder Social Security #_____ Policyholder Birthdate _____Employer_____

Dental Insurance Co _____ Group # _____ Policyholder ID _____

Emergency Contact Person:_____ **Emergency Contact Phone Number:**_____

X _____ Date_____

Patient or Guardian Signature

X _____ Date_____

X _____ Date_____

X _____ Date_____

PATIENT INFORMATION

Name_____M F

First MI Last Sex

Address_____City_____State_____Zip_____

Social Security # _____ Date of Birth _____

Check Appropriate: ____Minor ____Single ____Married ____Divorced ____Widowed ____Separated

If over 18 yrs old and on Parent's Insurance: Name of School: _____ FT____ PT_____

Employer: _____Phone:_____

Whom may we thank for your Referral? _____

Emergency Contact Name & Phone # _____

Phone # of Nearest Relative Not Living With You: _____

PARENT or LEGAL GUARDIAN INFORMATION **(ONLY if Patient is Under 18 years old)**

Name of Legal Guardian _____

Address_____ _____

Social Security # _____ Date of Birth_____ Home Phone _____

Is this person a patient in our office? ____ Yes ____ No Cell Phone _____

Previous Dentist Name & City:_____

How often do you brush:_____ Floss:_____

Special dental products used:_____

Rate your dental anxiety (circle): NONE MILD MODERATE SEVERE
Cause of anxiety (circle): sound of drill/instruments / shots/injections / worry of pain involved / past experience
What can we do to relieve your anxiety?_____
What would you like to change about your smile? _____
Would you like information about (circle): Whitening / Gum Disease / Orthodontics/ Proper Oral Hygiene/
Tooth Replacement options (implants, partial or denture)

I attest that the above information is complete, accurate and factual. Any changes are my responsibility to communicate to the front office staff of Ackerman Family Dental in a timely manner.

X_____ Date_____

Signature of Patient or Parent/ Guardian