HEALTH HISTORY

Date_____ Patient name_____ name you wish to be called _____
Physical address_____ Home Phone_____
City _____ State_____ Zip Code_____ Work Phone_____
Mailing address_____
City_____State_____ Zip code_____
Best Time and Place to Reach You_____
Sex: M F Age_____ Birth date_____ Single Married Widowed Separated Divorced
Patient SS#_____ Occupation_____ Employer_____
Employer address_____ Employer Phone_____
Spouse name_____ Birth date _____ SS#_____
Occupation_____ Spouse's Employer_____

IN CASE OF EMERGENCY PLEASE CONTACT (someone not living with you)
Name_____ Relationship to you_____
Address and Phone Number of Emergency Contact Person_____
Whom may we thank for sending you here? _____
Who is responsible for this account? _____Relationship to Patient_____

Insurance Company_____ Group Number_____
Is Patient Covered by Additional Insurance YES NO Subscriber's Name_____
Subscriber's Birth date _____ Subscriber's SS#_____ Relationship to Patient_____
Insurance Company_____Group Number_____

ASSINGMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with_____ and assign directly to doctor otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature Relationship Date

Reason for today's visit_____
Former dentist_____ Last dental visit_____

PLEASE CIRLE YES or NO TO INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING

1. bleeding gums while brushing or flossing? YES NO
2. are your teeth sensitive to hot or cold? YES NO
3. are your teeth sensitive or sweets liquids/food? YES NO
4. do you have any sores or lumps in your mouth? YES NO
5. do you have any problems with your jaw:
   - Clicking as you open or close your mouth YES NO
   - Difficulty opening or chewing YES NO
   - Pain (joint, ear, side of face) ? YES NO
   - Difficulty in chewing? YES NO
6. do you have frequent headaches? YES NO
7. have you had braces? YES NO
8. have you had difficult extractions? YES NO
9. do you smoke or chew tobacco? YES NO
10. have or had instructions on how to brush or care for you gums? YES NO
11. do you clench or grind your teeth? YES NO
12. loose teeth or loose fillings? YES NO
13. type of bristles used?
    HARD MEDIUM SOFT