General Patient
Health History Form

Patient Information

Patient's Name: ______________________ Age: ________ Birthdate: ____________

Name you like to be called: ______________ Hm Phone: ________ School: ________ Grade: ______

Address: ______________________ City: ____________ State: ______ Zip: ________

Social Security #: ____________________

Who may we thank for referring you to our office? ______________________________

Spouse/Additional Contact Information

Name: ______________________________

Address: ______________________ City: ____________ State: ______ Zip: ________

How long at this address? ______________________________

Social Security #: ______________ Birthdate: ____________ Relationship to Patient: ________

Employer: ______________ Occupation: ____________ No. of years employed: ________

Insurance Information

Insured Name: ______________ Insured's SS#: ____________ Insurance Co: ________

Insurance Co. Address: ______________________ Group #: ____________

Phone: ______________ Insured's Employer: ______________________

Do you have dual coverage? Yes No If yes:

Insu red's Name: ______________ Insured's SS#: ____________ Insured's Employer: ________

Ins .Co. Address: ______________ Group #: ____________ Phone: ____________

Phone: ______________ Insured's Employer: ______________________

Insurance Co. Address: ______________________________

M edical/Dental History (circle)

Physician's Name: ______________________ Phone: ____________

Dentists Name: ______________________ Phone: ____________

Yes No Are you currently under any medical treatment? If So What Kind? ______________

Yes No Do you have pain, clicking, and/or popping noises in the jaw?

Yes No Are you aware of either clenching or grinding of teeth?

Yes No Do you have frequent headaches? How often? ____________

Yes No Do you have ear problems? (Aches, ringing, dizziness, fullness)

Yes No Do you have difficulty breathing through the nose?

Yes No Do you have habits such as nail biting, finger or thumb sucking, lip or cheek biting?

Yes No Do you have speech problems, or are you in speech therapy?

Yes No Have you had your tonsils and/or adenoids removed?

Yes No Has there been any history of: Joint swelling Asthma TB Aids Ki dney Liver Condition Epilepsy Rheumatic fever Other major illnesses? ____________

Yes No Do you bleed easily?

Yes No Is there a tendency to faint or become dizzy?

Yes No Do you have allergies? (Sulphur, penicillin, novocaine, etc.) ______________

Yes No Are you currently taking any medication? List: ______________

Yes No Do you have a heart condition? Yes No Do you pre-medicate? Yes No
Cardiologist: ____________

Yes No Do you have sleep apnea?

Yes No Do yo u smoke or chew tobacco?

Yes No Have there been any injuries to the teeth? Explain ______________

Yes No Have you had any permanent teeth extracted?

Yes No Have we treated any other family members? Yes No Who: ____________

Signature: ______________________ Date: ____________

Date: ____________ Patient's Name: ______________________ Age: ________