HEALTH AND DENTAL HISTORY FORM — Dr Marie Calabrese

PATIENT INFORMATION

Patient Name: _____ Date: ___ / ___ / ___
Last First MI (Preferred Name)

Gender > ☐ Male ☐ Female Family Status > ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Social Security # *(if you have ins.):* _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: ____ (Mobile) _____

Address: _____
Street Apartment #

_____
City State Zip Code

E-Mail Address _____ Last dental visit date ___ / ___ / ___

How were you referred to our practice: _____

Reason for this visit? _____

If you could change anything about your smile, what would you change? _____

_____

Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please explain _____

*** <u>If patient is not financially responsible (i.e Child) we need parent or responsible party information</u> ***

The following is for: ☐ the patient's spouse ☐ the patient's parent or guardian ☐ the person responsible for payment

Name: _____
☐ Male ☐ Female ☐ Married ☐ Single ☐ Other

Social Security #: *(if you have ins.)* _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Mobile) _____

Address: _____
Street Apartment #

_____
City State Zip Code

EMPLOYMENT INFORMATION

The following is for: ☐ Parent or guardian ☐ Other (relationship) _____ * for person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Fill out the below information only if you have Dental Insurance or if different from above.

INSURANCE INFORMATION

(Only if you have DENTAL insurance)

Primary Insurance Plan Name / Address: _____

_____

Name of Insured (person): _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Child ☐ Spouse Other _____

(If you have secondary DENTAL insurance let us know)

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Have you ever had any of the following? Please check those that apply:

Allergies to:
- ☐ Dental Anesthetic
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Allergy other med.

_____

_____

- ☐ Seasonal Allergy
- ☐ Environmental Allergy
- ☐ Latex / rubber Allergy
- ☐ Other Allergy

_____

_____

- ☐ AIDS
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer / Tumors
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy / Seizure
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Headache / Migraine
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease

- ☐ Mental Health Care
- ☐ Anxiety Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ STD

Describe any :
Tobacco use -----

_____ / day or wk

Alcohol -----

_____ / day or wk

Soft Drinks -----

_____ / day or wk

Coffee / Tea ----

_____ / day or wk

Ounces of water -----

_____ / day or wk

Is your water fluoridated? (circle one)
Yes / No / Don't know

Is your diet medically supervised? (circle one)
Yes / No

Any unexplained change in weight? (circle one)
Yes / No

Dental Questions

How often do you brush your teeth?

_____ times / day
_____ times / week

How often do you floss your teeth ?

_____ times / day
_____ times / week
_____ times / month

Do your gums bleed when you brush or floss your teeth ? Yes / No

Are your teeth sensitive to: Hot / Cold / Sweet / Sour / Pressure / None (circle any)

Are you especially anxious or fearful about dentistry ? Yes / No

Do you have any jaw: pain / clicking / locking (circle any)

Have you had an injury to your head, neck or jaw ? Yes / No

Do you wear retainers, night guard or other appliance? Yes / No

Have you ever lost any teeth? Yes / No

Age of current partial or denture _____

Any mouth odor or unpleasant taste?
Yes / No

Have you ever had any:
- ☐ Periodontal treatment
- ☐ Orthodontic treatment
- ☐ Clenching / Grinding

Name of Physician: _____ Phone: _____
Do you have any other health problems that you would like to talk to the Doctor about? ☐ Yes ☐ No

List all Medications you are presently taking including herbal medications, vitamins, etc.

_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature _____ Date: _____

Consent for Services

All emergency dental services performed without previous financial arrangements, must be paid for in full at the time services are performed.
Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Any balance due is the patient's responsibility.
For children, regardless of custody or child support arrangements, it is the policy of this office that the parent who brings the child to the office for treatment is responsible, in full, for fees for services rendered or any balance remaining after insurance payments.
I grant my permission to your office to telephone me to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____
Signature of guarantor of payment / responsible party