NEW PATIENT HEALTH HISTORY FORM

Dr. David Coates DDS

Personal Information

Patients Name_____ Parent or Guardian Name_____

Address_____ City_____ State_____ Zip_____

Phone Number_____ Email_____

Dental Information

Do your gums bleed when you brush or floss? ○Y ○N
Are your teeth sensitive to cold, not, sweets or pressure? ○Y ○N
Does food or floss catch between your teeth? ○Y ○N
Is your Mouth dry? ○Y ○N
Have you had any periodontal (gum) treatments? ○Y ○N
Have you ever had orthodontic treatment? ○Y ○N
Have you had any problems associated with previous Dental treatment? ○Y ○N
Are you currently experiencing dental pain or discomfort? ○Y ○N
How many times a day do you brush? _____
How many times a week do you floss? _____
What is the reason for your dental visit today?_____

Do you have earaches or neck pains? ○Y ○N
Do you have any clicking, popping, or discomfort in jaw? ○Y ○N
Do you brux or grind your teeth? ○Y ○N
Do you have sores or ulcers in your mouth? ○Y ○N
Do you wear dentures or partials? ○Y ○N
Do you participate in active recreational activities? ○Y ○N
Have you ever had a injury to your head or mouth? ○Y ○N
Date of your last Dental Exam?_____
What was done at that exam?_____
_____

How do you feel about your smile?_____

Medical Information

Are you now under the care of a physician? ○Y ○N

Physician Name:_____

Address/City/State/Zip:_____

Are you in good health? ○Y ○N
Has there been change in your health in the past Year? ○Y ○N
If yes, what condition is being treated?
_____
_____

Are you taking any prescription or over the counter medications? ○Y ○N
If so, please list all medications:
_____
_____
_____

Date of last physical exam:_____

Joint Replacement. Have you had an orthopedic total joint(hip, Knee, elbow, finger) replacement? ○Y ○N
Date:_____
WOMEN ONLY: Are you pregnant? ○Y ○N
Number of weeks? _____
Taking birth control pills or hormonal replacement? ○Y ○N

Do you use tobacco (smoking,snuff,chew)? ○Y ○N
If so, how interested are you in stopping?
(Check one) ○VERY ○SOMEWHAT ○NOT INTERESTED

ALLERGIES: Are you allergic to or have you had a reaction to:
(To all yes responses, specify type of reaction)

Local anesthetics_____ ○Y ○N
Aspirin_____ ○Y ○N
Penicillin or other antibiotics_____ ○Y ○N
Barbiturates, sedatives, or sleeping pills_____ ○Y ○N
Sulfa drugs_____ ○Y ○N
Other_____ ○Y ○N

Metals_____ ○Y ○N
Latex (rubber)_____ ○Y ○N
Iodine_____ ○Y ○N
Food_____ ○Y ○N
Codeine or other narcotics_____ ○Y ○N

Please mark your response if you have or have not had any of the following diseases or problems.

Artificial (prosthetic) heart valve	○Y ○N	Autoimmune disease	○Y ○N
Previous infective endocarditis	○Y ○N	Rheumatoid arthritis	○Y ○N
Damaged valves in transplanted heart	○Y ○N	Systemic lupus erythematosus	○Y ○N
Congenital heart disease	○Y ○N	Asthma	○Y ○N
Cardiovascular disease	○Y ○N	Emphysema	○Y ○N
Angina	○Y ○N	Tuberculosis	○Y ○N
Arteriosclerosis	○Y ○N	Cancer/Chemotherapy/Radiation Treatment	○Y ○N
Congestive heart failure	○Y ○N	Chest pain upon exertion	○Y ○N
Damaged heart valves	○Y ○N	Chronic pain	○Y ○N
Heart Attack	○Y ○N	Sexually Transmitted disease	○Y ○N
Heart murmur	○Y ○N	Diabetes Type I or II	○Y ○N
Low blood pressure	○Y ○N	Eating disorder	○Y ○N
High blood pressure	○Y ○N	Malnutrition	○Y ○N
Other congenital heart defects	○Y ○N	Gastrointestinal disease	○Y ○N
Mitral valve prolapse	○Y ○N	G.E. Reflux/persistent heartburn	○Y ○N
Pacemaker	○Y ○N	Ulcers	○Y ○N
Rheumatic Fever	○Y ○N	Thyroid problems	○Y ○N
Abnormal bleeding	○Y ○N	Stroke	○Y ○N
Anemia	○Y ○N	Glaucoma	○Y ○N
Blood transfusion	○Y ○N	Hepatitis, jaundice or liver disease	○Y ○N
Hemophilia	○Y ○N	Epilepsy	○Y ○N
AIDS or HIV infection	○Y ○N	Fainting spells or seizures	○Y ○N
Arthritis	○Y ○N	Neurological disorders	○Y ○N
Recurrent Infections	○Y ○N	Kidney problems	○Y ○N
Osteoporosis	○Y ○N	Persistent swollen glands in neck	○Y ○N
Severe headaches/migraines	○Y ○N	Severe or rapid weight loss	○Y ○N

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax) or risedronate (Actonel), intravenous bisphosphonates (Aredia or Zometa) for osteoporosis or Paget's Disease? ○Y ○N
Date Treatment began:_____

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ○Y ○N

Name of physician or dentist making recommendation:_____ Phone #_____

Do you have any disease, condition, or problem not listed above that you think I should know about? ○Y ○N
Please explain:_____

_____

CONSENT FOR TREATMENT

Assignment and Authorization: I hereby consent to an xray, laboratory procedures, anesthesia, medical or surgical treatments rendered the patient which Dr. David J. Coates may consider or advise in the treatment of my case and guarantee payments of the charges incurred. I hereby authorize the above named doctor to release information requested on this form. I understand that half of my portion of the charges is due at the time of service, and the other half is due within 60 days from the date that service was rendered, I know I am responsible for payment of my account.

Terms: Net 30 days from the date of the invoice unless otherwise indicated above. A finance charge of 1-1/2% per month (annual percentage rate 18%) of the unpaid balance will be added monthly. Should collection become necessary, the responsible party agrees to pay an additional 33.33% collection fee, and all legal fees of collection, with or without suit, including attorney fees and court cost.

Guests Signature_____ Date_____

Parent or Guardian Signature(who is responsible for guest)_____