

Tassajara Dental Care

Today's Date _____

Referred by _____

PATIENT NAME _____ SEX _____ MARITAL STATUS _____ BIRTHDATE _____ AGE _____
Last First MI

MAILING ADDRESS _____

City

State

Zip

HOME PHONE () _____ WORK PHONE () _____ CELL PHONE () _____

IF PATIENT IS A MINOR: STUDENT? Y / N SCHOOL _____

MOTHER _____
Name Address

HOME PHONE () _____ WORK PHONE () _____ CELL PHONE () _____

FATHER _____
Name Address

HOME PHONE () _____ WORK PHONE () _____ CELL PHONE () _____

WHO IS FINANCIALLY RESPONSIBLE FOR ACCOUNT? _____ DRIVER'S LICENSE # _____

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE

SUBSCRIBER _____ DATE OF BIRTH _____ RELATION TO PATIENT _____

SOC. SECURITY# _____ EMPLOYER _____

INSURANCE CO.: _____ ID # _____ GROUP# _____

ADDRESS _____ PHONE () _____

SECONDARY DENTAL INSURANCE

SUBSCRIBER _____ DATE OF BIRTH _____ RELATION TO PATIENT _____

SOC. SECURITY# _____ EMPLOYER _____

INSURANCE CO.: _____ ID # _____ GROUP# _____

ADDRESS _____ PHONE () _____

MEDICAL INSURANCE

SUBSCRIBER _____ DATE OF BIRTH _____ RELATION TO PATIENT _____

SOC. SECURITY# _____ EMPLOYER _____

INSURANCE CO.: _____ ID # _____ GROUP# _____

ADDRESS _____ PHONE () _____

WHOM SHOULD WE CONTACT IN CASE OF EMERGENCY? _____

HOME PHONE () _____ CELL PHONE () _____ WORK PHONE () _____

PHYSICIAN NAME, ADDRESS, PHONE _____

HEALTH HISTORY

Patient's Name	Date of Birth	Height	Weight	Date
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Answer all questions by circling Yes (Y) or No (N)

All responses are kept confidential

1. Are you in good health? Y N
2. Has there been any change in your general health in the past year? Y N
3. Date of last physical exam _____
4. Are you now under a physician's care for a particular problem? Y N
5. Have you ever had any serious illnesses, operations or hospitalizations? If so, describe: Y N

- I. Are you taking or *have you ever taken* Bisphosphonates for osteoporosis, multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa)? Y N
- J. Have you ever been advised not to take a medication? Y N
- K. Please list any and all medications taken, including prescription medications, diet drugs, over-the-counter medications, herbal or holistic remedies, vitamins or minerals: _____

6. DO YOU HAVE OR HAVE YOU EVER HAD:
- A. Rheumatic Fever or Rheumatic Heart Disease? Y N
 - B. Congenital Heart Disease? Y N
 - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker)? Y N
 - D. Lung Disease (Asthma, Emphysema, COPD, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? Y N
 - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness? Y N
 - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? Y N
 - G. Liver Disease (Jaundice, Hepatitis)? Y N
 - H. Kidney Disease? Y N
 - I. Diabetes? Y N
 - J. Thyroid Disease (Goiter)? Y N
 - K. Arthritis? Y N
 - L. Stomach Ulcers or Colitis? Y N
 - M. Glaucoma? Y N
 - N. Osteoporosis? Y N
 - O. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? Y N
 - P. Radiation (X-ray) treatment for Cancer? Y N
 - Q. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? Y N
 - R. Sinus or Nasal problems? Y N
 - S. Any disease, drug or transplant operation that has depressed your immune system? Y N

8. ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:
- A. Local Anesthesia (Novacain, etc.)? Y N
 - B. Penicillin or other antibiotics? Y N
 - C. Sedatives, Barbiturates? Y N
 - D. Aspirin or Ibuprofen? Y N
 - E. Codeine or other pain killers? Y N
 - F. Latex or Rubber products? Y N
 - G. Metal of any kind? Y N
 - H. Chemicals or jewelry (rash or sensitivity)? Y N
 - I. Food products? Y N
 - J. Other allergies or reactions? Please list Y N

9. Do you smoke or chew Tobacco? Y N
How much per day? _____
10. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? Y N
11. Have you had any serious problems associated with any previous dental treatment? Y N
12. Have you or an immediate family member had any problem associated with intravenous anesthesia? Y N
13. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? Y N
14. Do you wish to talk to the doctor privately about anything? Y N
15. Have you ever had a bone density scan? Y N
16. FOR WOMEN ONLY

7. ARE YOU USING ANY OF THE FOLLOWING:
- A. Antibiotics? Y N
 - B. Anticoagulants (Blood Thinners)? Y N
 - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? Y N
 - D. High Blood Pressure medications? Y N
 - E. Steroids (Cortisone, Prednisone, etc.)? Y N
 - F. Tranquilizers? Y N
 - G. Insulin or Oral Anti-Diabetic drugs? Y N
 - H. Digitalis, Inderal, Nitroglycerin or other heart drug? Y N

- A. Are you Pregnant, or is there any chance you might be Pregnant? Y N
- B. Are you nursing? Y N
- C. If you are using Oral Contraceptives, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the importance of a truthful and complete Health History to assist my dentist in providing the best care possible. I have had the opportunity to discuss my Health History with my dentist.

Date	Signature of Person Completing Health History	Doctor's Initials
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