Patient Health History

2332 Centerville Road, Tallahassee, Fl 32308 Phone (850) 386-3333 Fax (850) 386-3363

(Please Print) **Date**__________________

Patient Name__________________ _____ _____________________**DOB**_________ **Driver's License#**_______________________
First *MI* *Last*

Mailing Address____________________________________ **City**_________________________ **State**________
Zip_____________

SS# _______________ **Sex** ☐Male ☐Female **Marital Status** *(Please Check)* ☐Single ☐Married ☐Widow ☐Divorced ☐Other

Home Phone# (_____**)** ___________**Work Phone# (**_____**)** __________**Cell Phone# (**_____**)** __________ **Other (**_____**)** __________

Occupation____ **Employer**____

Employer's Address_____________________________________ **City**______________________ **State**_______ **Zip**_____________

If Student, Name of School/College_________________________ **City**______________________ **State**_______ **Zip**_____________

Whom May We Thank for Referring You to Our Office? ____

Person to Contact in Case of Emergency________________________________ **Phone# (**_____**)**_____________________________

If the person responsible for this patients account is different from the patient or if this is a minor, the responsible party must fill out the section below. Otherwise, please skip to the section titled "Insurance Information"

Name of Responsible Party____________________________________ **Relationship to Patient**______________________________

Mailing Address____________________________________ **City**_________________________ **State**________
Zip_____________

SS# ______________________ **Date of Birth**____________________ **Driver's License#**____________________________________

Sex ☐Male ☐Female **Marital Status** *(Please Check)* ☐Single ☐Married ☐Widow ☐Divorced ☐Other

Home Phone# (_____**)** ___________ **Work Phone# (**_____**)** __________**Cell Phone# (**_____**)** __________ **Other (**_____**)** __________

Occupation____ **Employer**____

Employer's Address_____________________________________ **City**______________________ **State**_______ **Zip**_____________

Insurance Information

Policy Holders Name__________________________ **Relation to Patient**_______________ **SS#** _________________ **DOB**_________

Employer__________________ **Employer's Address**_____________________ **City**________________ **State**_____ **Zip**____________

Insurance Co.__________________________ **Address**_______________________ **City**______________ **State**_____ **Zip**__________

Group Number___________________ **Subscriber's ID Number**_____________________ **Phone Number (**_____**)** _______________

Health History

Answers to the following questions are for our records and will be considered confidential.

- Have you or any member of your family been seen by us before? Yes No
  If yes, which family member(s)? ____
- Date of last dental examination______________________ Date of last dental x-rays_____________________
- Previous dentist name______________________________ City/State_________________________________
- Are you having discomfort at this time? *Yes* *No*
- *Do you feel nervous about having dental treatment?* *Yes* *No*
- *Have you ever had a bad experience in a dental office?* *Yes* *No*
- *Is there anything you dislike about your smile?* *Yes* *No*
- *Have you taken any medications or drugs in the past two years?* *Yes* *No*
- *Are you taking any vitamins or herbal supplements?* *Yes* *No*
- *Have you ever had excessive bleeding requiring special treatment?* *Yes* *No*
- *Have you had previous surgeries? Including Knee, Hip & Heart Valve Replacement* *Yes* *No*

Medical History

Allergies____

Please list all medications you are currently taking____

Are you currently taking any blood thinners? Including aspirin____

Please check to indicate if you have had any of the following:

❑AIDS	❑Chemotherapy	❑Hepatitis	❑Scarlet Fever
❑Anemia	❑Cholesterol	❑High Blood Pressure	❑Shortness of Breath
❑Arthritis	❑Diabetes	❑HIV Positive	❑Skin Rash
❑Artificial Heart Valves/Joints	❑Epilepsy	❑Jaw Pain	❑Stroke
❑Asthma	❑Fainting	❑Kidney Disease	❑Swelling of Feet
❑Back Problems	❑Glaucoma	❑Liver Disease	❑Thyroid Problems
❑Bleeding Abnormally	❑Headaches	❑Mitral Valve Prolapse	❑Tobacco Habit
❑Blood Disease	❑Heart Murmur	❑Nervous Problems	❑Tonsillitis
❑Cancer	❑Heart Problems	❑Psychiatric Care	❑Tuberculosis
❑Chemical Dependency	Describe__________	❑Respiratory Disease	❑Ulcer
❑Circulatory Problems	❑Hemophilia	❑Rheumatic Fever	❑Venereal Disease

Women: Are you pregnant? Yes No If yes, when is your due date? _______________

Are you breastfeeding? Yes No

Are you taking oral contraceptives? Yes No

Dental History

Have you ever experienced any of the following problems with your jaw?

❑ Clicking	❑ Pain in or around your ears	❑ Difficulty opening or closing
❑ Difficulty chewing	❑ History of trauma	❑ Diagnosed with TMJ/TMD

Do you currently have any problems listed below?

❑ Swelling	❑ Bleeding Gums	❑ Bad Taste
❑ Sore Gums	❑ Lumps or growth around mouth	❑ Prolonged bleeding after extraction
❑ Sensitivity to heat	❑ Sensitivity to sweets	❑ Sensitivity when biting
❑ Sensitivity to cold	❑ Loose Teeth	❑ Grinding teeth
❑Sores around your mouth	❑Bad breath (Halitosis)	❑Food collecting between your teeth

Please circle yes or no

Have you had difficult extractions in the past?	Yes	No
Have you ever had oral hygiene instructions?	Yes	No
Have you ever been told you have gum problems?	Yes	No
Is there anything related to your medical and dental history that you have not indicated above?	Yes	No

Is yes, please explain: ____

Certification and Assignment

To the best of my knowledge the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with________________________________ and assign directly to Dr. Makeba Earst of All About Smiles Dental Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

I authorize the above named dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

____ ____________________

Signature of Patient, Parent, Guardian or Personal Representative *Date*

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Please print name of Parent, Guardian or Personal Representative