Health History

Muir Family Dentistry

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About You

Today's Date: Email Address:

Name: Preferred Name: ☐ Male ☐ Female

Birthdate: Age: Social Security #: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home Address:
Street City State Zip

	Number	Best # to confirm appointment	O.K. to leave detailed message
Home Phone		Yes/No	Yes/No
Work Phone		Yes/No	Yes/No
Cell Phone		Yes/No	Yes/No

Employer: How long there: Occupation:

Employer's address:

Whom may we thank for referring you? Other family members seen by us:

Emergency Contact at Different Address

Name: Home phone: Work phone: Cell phone:

Address: Relation:

Spouse Information

Name: Birthdate: Social Security #:

Employer: Work phone: Ext: Cell phone:

Insurance Information

PRIMARY INSURANCE Dental coverage? ☐ Yes ☐ No Orthodontic coverage? ☐ Yes ☐ No Medical coverage? ☐ Yes ☐ No

Insurance Co. name: Phone: ( ) Group # (Plan, Local or Policy #)

Insurance Co. address:

Insured's name: Insured's Social Security #: Birthdate: Relation:

Insured's employer: Insured's ID#:

SECONDARY INSURANCE Dental coverage? ☐ Yes ☐ No Orthodontic coverage? ☐ Yes ☐ No Medical coverage? ☐ Yes ☐ No

Insurance Co. name: Phone: ( ) Group # (Plan, Local or Policy #)

Insurance Co. address:

Insured's name: Insured's Social Security #: Birthdate: Relation:

Insured's employer: Insured's ID#:

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Dental History

Reason for your visit today: _____ Previous/Present Dentist: _____ Date last seen: _____

Are you currently in pain? ☐ Yes ☐ No Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Are your teeth sensitive to heat, cold or anything else? _____ Do you brush daily? ☐ Yes ☐ No Floss daily? ☐ Yes ☐ No

Medical History

Do you require antibiotics for dental treatment? ☐ Yes ☐ No Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Reason: Heart valve, artificial joint, other: _____ Are you currently under the care of a physician? ☐ Yes ☐ No

Are you now or have you ever taken bisphosphonate type medication Please explain: _____

for osteporosis, e.g. Fosamax, Boniva, Zometa? ☐ Yes ☐ No Physician's name: _____

FOR WOMEN: Do you take birth control medication? ☐ Yes ☐ No City/Zip: _____

Are you pregnant? ☐ Unsure ☐ Yes ☐ No Phone #: _____ Date of last visit: _____

If so, how many weeks? _____ Are you nursing? _____

Circle yes or no whether you have or have had any of the following:

Y N Abnormal Bleeding	Y N Depression	Y N Glaucoma	Y N Lupus	Y N Sleep Apnea
Y N Alcohol Abuse	Y N Diabetes	Y N Hay Fever	Y N Oral STD	Y N Snoring
Y N Anemia	Y N Difficulty Breathing	Y N Heart Attack	Y N Osteoporosis	Y N Steroid Therapy
Y N Anxiety	Y N Drug Abuse	Y N Heart Murmur	Y N Pacemaker	Y N Stroke
Y N Arthritis	Y N Eating Disorder	Y N Heart Surgery	Y N Persistent Cough	Y N Thyroid Problems
Y N Artificial Bones Joints	Y N Emphysema	Y N Hemophilia	Y N Psychiatric Care	Y N Tonsillitis
Y N Artificial Heart Valves	Y N Epilepsy	Y N Hepatitis	Y N Radiation Treatment	Y N Tuberculosis (TB)
Y N Asthma	Y N Ever Hospitalized	Y N Herpes	Y N Rheumatic Fever	Y N Ulcers and/or
Y N Cancer	Y N Fainting Spells	Y N High Blood Pressure	Y N Scarlet Fever	Acid Reflux
Y N Chemotherapy	Y N Fever Blisters and/or	Y N HIV+/AIDS	Y N Seizures	
Y N Chicken Pox	Oral Herpes	Y N Kidney Problems	Y N Shingles	
Y N Colitis	Y N Frequent Headaches	Y N Liver Disease	Y N Sickle Cell Disease	
Y N Congenital Heart Defect	and/or Migraines	Y N Low Blood Pressure	Y N Sinus Problems	

Please list any serious medical conditions and surgeries that you have experienced: _____

Are you taking any prescription or over-the-counter drugs? (if more than three, please ask for additional form)

1. _____ 2. _____ 3. _____

Circle yes or no whether you are allergic to any of the following:

Y N Aspirin	Y N Dental Anesthetics	Y N Jewelry/Metals	Y N Penicillin	Y N Sulfa Drugs	Y N Other
Y N Codeine	Y N Erythromycin	Y N Latex	Y N Sedatives	Y N Tetracycline	

Please list anything additional that causes allergic reactions: _____

I affirm that the information I have given is correct to the best of my knowledge. It will be held in strict confidence, and it is my responsibility to inform the office of any changes in my medical status.

Signature: _____ Date: _____

Relationship to patient: _____

Please do not write in this section until asked to do so at a later date.

MEDICAL HISTORY UPDATE: I have read my medical history and confirmed that it states past and present medical conditions.

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

7/2019