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

Reason: Heart valve, artificial joint, other: ______

Are you now or have you ever taken bisphosphonate type medication for osteporosis, e.g. Fosamax, Boniva, Zometa? ☐ Yes ☐ No

FOR WOMEN: Do you take birth control medication? ☐ Yes ☐ No

Are you pregnant? ☐ Unsure ☐ Yes ☐ No

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

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: ______

Physician's name: ______

City/Zip: ______

Phone #: ______ Date of last visit: ______

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

Y N Abnormal Bleeding
Y N Alcohol Abuse
Y N Anemia
Y N Anxiety
Y N Arthritis
Y N Artificial Bones Joints
Y N Artificial Heart Valves
Y N Asthma
Y N Cancer
Y N Chemotherapy
Y N Chicken Pox
Y N Colitis
Y N Congenital Heart Defect

Y N Depression
Y N Diabetes
Y N Difficulty Breathing
Y N Drug Abuse
Y N Eating Disorder
Y N Emphysema
Y N Epilepsy
Y N Ever Hospitalized
Y N Fainting Spells
Y N Fever Blisters and/or Oral Herpes
Y N Frequent Headaches and/or Migraines

Y N Glaucoma
Y N Hay Fever
Y N Heart Attack
Y N Heart Murmur
Y N Heart Surgery
Y N Hemophilia
Y N Hepatitis
Y N Herpes
Y N High Blood Pressure
Y N HIV+/AIDS
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure

Y N Lupus
Y N Oral STD
Y N Osteoporosis
Y N Pacemaker
Y N Persistent Cough
Y N Psychiatric Care
Y N Radiation Treatment
Y N Rheumatic Fever
Y N Scarlet Fever
Y N Seizures
Y N Shingles
Y N Sickle Cell Disease
Y N Sinus Problems

Y N Sleep Apnea
Y N Snoring
Y N Steroid Therapy
Y N Stroke
Y N Thyroid Problems
Y N Tonsillitis
Y N Tuberculosis (TB)
Y N Ulcers and/or Acid Reflux

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

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: ______