Maple Hill Dentistry

Health History Form

Personal Information

Name:_____ Date of Birth_____
Primary Phone:_____ Secondary Phone_____
Email Address:_____
Home Address (City, State, Zip):_____
Emergency Contact (Name and Number):_____

Insurance Information

Employed By:_____ Dental Insurance Company:_____
Insurance Member ID Number:_____ Your SSN:_____
Are you the policyholder? Yes No If not, who?_____
Policy Holder DOB:_____ Policy Holder SSN:_____

Dental History

When was your last dental visit?_____
Is Your Dental Health Important? ❑ Not Important ❑ Somewhat Important ❑ Very Important
What is Your Main Reason for Your Visit here today?_____

Do You Have Tooth Pain/Sensitivity?	❑ Yes ❑ No
Do You Have Any Broken/Chipped Teeth?	❑ Yes ❑ No
Do You Experience Jaw Pain?	❑ Yes ❑ No
Do Your Gums Ever Bleed?	❑ Yes ❑ No
Have You Used Tooth Whitening Products?	❑ Yes ❑ No
Have You Ever Had Braces?	❑ Yes ❑ No
Have You Ever Had a 'Root Canal?'	❑ Yes ❑ No
Are You Missing Any Teeth?	❑ Yes ❑ No
Do You Wear a Dental Night Guard?	❑ Yes ❑ No
Do You Experience Dry Mouth?	❑ Yes ❑ No
Do You Use Fluoride Mouth Rinse?	❑ Yes ❑ No
Have You Ever Had Gum (Periodontal) Treatments?	❑ Yes ❑ No
Does Anyone in Your Family Wear Dentures?	❑ Yes ❑ No
Do You Require Antibiotics Before Dental Treatment?	❑ Yes ❑ No
Ever had a Serious Problem with Previous Dental Work?	❑ Yes ❑ No
You Drink Soda Pop and/or Energy Drinks	❑Never ❑Sometimes ❑Frequently
You Drink Coffee and/or Tea	❑Never ❑Sometimes ❑Often

Your Favorite Snacks are?_____

How Often Do You Brush your Teeth?_____Floss?_____

How Did You Hear About Our Dental Practice?_____

What is the MOST important thing you are looking for in your dentist and dental office?_____

Health History

Are You Currently Under Care of a Physician? ❑ Yes ❑ No
Where Do You Go For Medical Care?_____Most Recent Visit?_____
Height?_____ Weight?_____
Do you use Tobacco in any form? ❑ Yes ❑ No How many years have you used?_____

Allergies

Do You Have any Allergies or "Bad Reactions" to the Following?

Penicillin	❑ Yes	❑ No	Latex	❑ Yes	❑ No
Clindamycin	❑ Yes	❑ No	Metals	❑ Yes	❑ No
Erythromycin	❑ Yes	❑ No	Other	❑ Yes	❑ No

If yes, describe details of your reaction:_____

Conditions

Do You Currently Have Any of the Following?

Alzheimer's	❑ Yes	❑ No	Glaucoma	❑ Yes	❑ No
Anemia	❑ Yes	❑ No	HIV/AIDS	❑ Yes	❑ No
Angina Pectoris	❑ Yes	❑ No	Heart Attack History	❑ Yes	❑ No
Arthritis	❑ Yes	❑ No	Heart Surgery History	❑ Yes	❑ No
Anxiety	❑ Yes	❑ No	Hemophilia	❑ Yes	❑ No
Artificial Heart Valve	❑ Yes	❑ No	Hepatitis A, B, or C	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	High Blood Pressure	❑ Yes	❑ No
Acid Reflux	❑ Yes	❑ No	Joint Replacement History	❑ Yes	❑ No
Cancer	❑ Yes	❑ No	Kidney Problems	❑ Yes	❑ No
Chest Pain	❑ Yes	❑ No	Liver Problems	❑ Yes	❑ No
Heart Defects	❑ Yes	❑ No	Osteoporosis	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No	Pacemaker	❑ Yes	❑ No
Dialysis	❑ Yes	❑ No	Psychiatric Conditions	❑ Yes	❑ No
Difficulty Breathing	❑ Yes	❑ No	Pregnant/Nursing	❑ Yes	❑ No
Difficult Seeing	❑ Yes	❑ No	Active STD or STI	❑ Yes	❑ No
Difficulty Hearing	❑ Yes	❑ No	Sinus Problems	❑ Yes	❑ No
Depression	❑ Yes	❑ No	Stroke History	❑ Yes	❑ No
Drug Abuse History	❑ Yes	❑ No	Thyroid Problems	❑ Yes	❑ No
Emphysema	❑ Yes	❑ No	Tuberculosis	❑ Yes	❑ No
Epilepsy	❑ Yes	❑ No	Ulcers	❑ Yes	❑ No
Endocarditis History	❑ Yes	❑ No			

Explain Details:_____

Medications
Please List the Medications you Regularly Take:

_____
_____

Have You Ever Taken any Bisphosphonate drugs, such as Fosamax or Zoledronate? ❑ Yes ❑ No
Anything Else You Would Like us to Know Regarding Your Health Status?

_____
_____
_____

Thank You!

_____

Patient Signature Date