# HEALTH HISTORY

**The following information is very important and will aid us in caring for your dental needs.**

| | Circle | |
|---|---|---|
| 1. Are you having pain or discomfort at this time? | YES | NO |
| 2. Have you ever fainted in a dental office? | YES | NO |
| 3. Have you had a serious accident or head injury? | YES | NO |
| 4. Have you been a patient in the hospital during the past two years? | YES | NO |
| For what reason? _____ | | |
| 5. Do you smoke or use tobacco? | YES | NO |
| 6. Do you use controlled or recreational drugs? | YES | NO |
| 7. Do you drink alcohol? | YES | NO |
| How often? _____ | | |
| 8. Have you been under the care of a medical doctor during the past two years? | YES | NO |
| 9. Name of Physician _____ | | |
| Address _____ Phone _____ | | |
| 10. Are you now taking any medication, drugs, vitamins or supplements? | YES | NO |
| If yes, please list _____ | | |
| 11. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? | YES | NO |
| If yes, please list _____ **Are you allergic to latex?** | YES | NO |

## 12. Indicate which of the following you have had or have at present. Circle "Yes" or "No" to each item.

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Heart Failure or Attack | YES | NO | Persistent Cough | YES | NO | Hepatitis A (infectious) | YES | NO |
| Heart Disease | YES | NO | Tuberculosis (TB) | YES | NO | Hepatitis B | YES | NO |
| Angina Pectoris | YES | NO | Asthma | YES | NO | Hepatitis (other) | YES | NO |
| High Blood Pressure | YES | NO | Hay Fever | YES | NO | Liver Disease | YES | NO |
| Mitral Valve Prolapse | YES | NO | Sinus Trouble | YES | NO | Yellow Jaundice | YES | NO |
| Heart Murmur | YES | NO | Allergies or Hives | YES | NO | Blood Transfusion | YES | NO |
| Rheumatic Fever | YES | NO | Diabetes | YES | NO | Alcohol or Drug Addiction | YES | NO |
| Congenital Heart Lesions | YES | NO | Thyroid Disease | YES | NO | Hemophilia | YES | NO |
| Scarlet Fever | YES | NO | Radiation Therapy | YES | NO | Venereal Disease (Syphilis, Gonorrhea) | YES | NO |
| Replacement Heart Valve | YES | NO | Chemotherapy (Cancer, Leukemia) | YES | NO | Cold Sores Fever Blisters | YES | NO |
| Heart Pacemaker | YES | NO | Arthritis | YES | NO | Epilepsy or Seizures | YES | NO |
| Heart Surgery | YES | NO | Rheumatism | YES | NO | Fainting or Dizzy Spells | YES | NO |
| Artificial Joints (Hip, Knee) | YES | NO | Cortisone Medicine | YES | NO | Anxiety | YES | NO |
| Anemia | YES | NO | Blood Thinners | YES | NO | Depression | YES | NO |
| Stroke | YES | NO | Glaucoma | YES | NO | Psychiatric Treatment | YES | NO |
| Stomach Ulcers | YES | NO | Pain in Jaw Joints | YES | NO | Sickle Cell Disease | YES | NO |
| Cosmetic Surgery | YES | NO | A.I.D.S. | YES | NO | Bruise Easily | YES | NO |
| Emphysema | YES | NO | HIV Positive | YES | NO | Allergies to Jewelry | YES | NO |

| | | |
|---|---|---|
| 13. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? | YES | NO |
| 14. Do your ankles swell during the day? | YES | NO |
| 15. Do you use more than 2 pillows to sleep? | YES | NO |
| 16. Have you lost or gained more than 10 lbs. in the past year? | YES | NO |
| 17. Do you ever wake up from sleep short of breath? | YES | NO |
| 18. Are you on a special diet? | YES | NO |
| 19. Do you bleed excessively when cut? | YES | NO |
| 20. Has your medical doctor ever said you have a cancer or tumor? | YES | NO |
| 21. Do you have any disease, condition or problem not listed? | YES | NO |
| Please describe _____ | | |
| 22. Is there any other information concerning your health that we should know about? | YES | NO |
| Please describe _____ | | |

Are you pregnant? ❑ YES ❑ NO If yes, what month? _____ Are you taking birth control pills? ❑ YES ❑ NO

Are you nursing? ❑ YES ❑ NO

Reviewed by _____

*I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I verify that the above information is true and correct to the best of my belief. I hereby authorize Boulevard Dental Associates and their staff to perform for me and/or my dependents such dental treatment, medication or therapy as they deem appropriate and in connection therewith to take or prepare x-rays, models or other diagnostic aids. I acknowledge that the performance of dental services (especially the use of anesthetic) inherently involves some risk.*

BOULEVARD DENTAL ASSOCIATES, PC

Patient _____ Date _____

Parent or Responsible Party _____ Relationship to Patient _____

## Patient Information

Date _____

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____ Preferred Form of Contact _____

Birthdate _____ Social Security # _____

If patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____

## Responsible Party Information

❑ I am my own responsible party

Name _____ _____
Last First Middle Marital Status

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How Long at This Address _____ Home Phone _____ Work Phone _____ Cell Phone _____

Previous Address (if less than three years) _____
Street City State Zip

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name: _____

Spouse's Date of Birth: _____ Spouse's Employer _____

Employer _____ Work Phone _____

## Dental Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____ Insured's DOB _____

Insurance Company _____ Group No. _____ Phone # _____

Do you have dual coverage? ❑ YES ❑ NO If yes: _____

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____ Phone # _____

Do you have dual coverage? ❑ YES ❑ NO If yes: _____ Employer _____

Insured's Employer: _____

## Emergency Information

Person to contact in case of emergency _____

Complete Address _____

Phone Home _____ Work _____

BOULEVARD
DENTAL ASSOCIATES, PC

Signature (Parent's Signature of Minor) _____

Update (date and initial) _____ _____ _____ _____ _____