Welcome to Fresh Dental Smiles

7100 West Commercial Blvd., Suite 108, Lauderhill, Florida 33319

Health History Form

Name _____ Date of Birth _____/_____/_____ SS # _____/_____/_____

☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Address _____ City _____ State _____ Zip_____

Home_____-_____-_____ Work _____-_____-_____ Mobile_____-_____-_____ Email _____

Patient's or parent's employer _____ Work _____-_____-____ Driver's License_____-_____-_____

Spouse or parent's name _____ Employer _____ Work _____-_____-_____

Person responsible for this account _____ Relationship _____ Work _____-_____-_____

Do you have dental insurance? ☐ Yes ☐ No If yes, Group carrier _____ Phone _____-_____-_____

Has any member of your family been treated in our dental office? ☐ Yes ☐ No If yes, Name _____

Name of former dentist _____ City _____ Work _____-_____-_____

Do you have a Living Will? ☐ Yes ☐ No What is your primary language? _____

Person to contact in case of emergency _____ Relationship _____ Phone _____-_____-_____

Pharmacy's Name _____ Phone _____-_____-_____

Purpose of visit/ Chief complaint _____ Referred by_____

Are you under the care of a physician? ☐ Yes ☐ No If yes, date of last physical exam _____/_____/_____

Physician's name _____ City _____ Work _____-_____-_____

Overall general health ☐ Excellent ☐ Good ☐ Fair ☐ Poor In the past year any change in your general health? ☐ Yes ☐ No

Have you ever had any serious illness or hospitalization? ☐ Yes ☐ No If yes, describe: _____

Do you have sleep apnea? ☐ Yes ☐ No Do you wear a night guard or any other device? ☐ Yes ☐ No

Are you now under medical treatment for a problem? ☐ Yes ☐ No If yes, for what reason? _____

What medication(s) are you taking? _____

Are you taking any of the following medications?

☐ Yes ☐ No Antibiotics?
☐ Yes ☐ No High Blood Pressure Medications?
☐ Yes ☐ No Blood Thinners such as Coumadin, Plavix?
☐ Yes ☐ No Motrin, Aleve, Ibuprofen?
☐ Yes ☐ No Aspirin?

☐ Yes ☐ No Tranquilizers?
☐ Yes ☐ No Steroids such as Cortisone?
☐ Yes ☐ No Insulin or Oral Anti-Diabetic Drugs?
☐ Yes ☐ No Other _____

☐ Yes ☐ No Digitalis, Inderal, Nitroglycerin, or other Heart Drugs?

Are you taking, or have ever taken any of the following medications?

☐ Yes ☐ No Fosamax, Actonel, or Boniva for Osteoporosis?
☐ Yes ☐ No Aredia or Zometa for Multiple Myeloma or Cancer?

Please check those conditions that now or have ever pertained to you:

☐ Yes ☐ No Heart murmur
☐ Yes ☐ No Heart disease
☐ Yes ☐ No Heart surgery
☐ Yes ☐ No Heart Attack or Stroke
☐ Yes ☐ No Cardiac Pacemaker
☐ Yes ☐ No Mitral Valve Prolapse
☐ Yes ☐ No Valve Replacement
☐ Yes ☐ No Angina
☐ Yes ☐ No Rheumatic Fever
☐ Yes ☐ No Low Blood Pressure

☐ Yes ☐ No High Blood Pressure
☐ Yes ☐ No Bleeding Problems
☐ Yes ☐ No Hemophilia
☐ Yes ☐ No Anemia
☐ Yes ☐ No Hepatitis or Jaundice
☐ Yes ☐ No Ulcers or Colitis
☐ Yes ☐ No Kidney Disease
☐ Yes ☐ No Liver Disease
☐ Yes ☐ No Cancer
☐ Yes ☐ No Radiation Treatment

☐ Yes ☐ No AIDS
☐ Yes ☐ No HIV Infection
☐ Yes ☐ No Herpes
☐ Yes ☐ No Venereal Disease
☐ Yes ☐ No Drug Dependency
☐ Yes ☐ No Artificial Implants
☐ Yes ☐ No Joint Replacement
☐ Yes ☐ No Arthritis
☐ Yes ☐ No Epilepsy
☐ Yes ☐ No Sinus Troubles

☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Respiratory Problems
☐ Yes ☐ No Thyroid Disease
☐ Yes ☐ No Glaucoma
☐ Yes ☐ No Mental Disorder
☐ Yes ☐ No Nervous Disorder
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Clicking of Jaw Joint
☐ Yes ☐ No Grind or Clench Teeth
☐ Yes ☐ No Other _____

Are you allergic to or have you had any reactions to the following?

☐ Yes ☐ No Local anesthesia such as Lidocaine or Novocain?
☐ Yes ☐ No Penicillin or other Antibiotics?
☐ Yes ☐ No Codeine or other Narcotics?
☐ Yes ☐ No Aspirin or Ibuprofen?
☐ Yes ☐ No Sedatives or Barbiturates?
☐ Yes ☐ No Latex or Rubber Products?

☐ Yes ☐ No Iodine?
☐ Yes ☐ No Sulfa?
☐ Yes ☐ No Other _____

If yes, explain reaction(s) _____

For women only:

☐ Yes ☐ No Are you pregnant, or think you may be pregnant?
☐ Yes ☐ No Are you nursing?
☐ Yes ☐ No If you are taking oral contraceptives with antibiotics, please consult with your physician for further guidance.

Permit for Treatment, Authorization, and Release

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits, otherwise payable to me. I understand that my dental carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf or my dependent, and fees are due upon completion of visit. I am aware that there will be a charge for not rescheduling or canceling my appointment 24 hours in advance.

Signed_____ Date ____/____/____ Signed_____ Date ____/____/____

Signature of Patient (Parent, or Guardian if Minor) Dentist's Signature