WARMSTONE FAMILY DENTISTRY

PATIENT HEALTH HISTORY FORM

(Please Print)

PATIENT INFORMATION

Date (mm-dd-yyyy):	How did you hear about us?		Name of patient's physician:		
Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Birth date (mm-dd-yyyy):
Street address:		Home phone no.:			Mobile phone no.:
City:	Province:	Postal code:	Email address:		

INSURANCE INFORMATION

Is the patient covered by dental insurance? ❑ Yes ❑ No		Name of insurance company:	
Policy no:	Certificate no:	Subscriber's name:	Subscriber's birth date (mm-dd-yyyy):
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Common Law			
Name of secondary insurance company (if applicable):		Policy no:	Certificate no:
Subscriber's name:		Subscriber's birth date (mm-dd-yyyy):	
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Common Law			

DENTAL HISTORY

Approximate date of last dental visit?	❑ This is my first time ❑ 3-6 months ❑ 1 year ❑ 2–4 years ❑ 5+ years
Has the patient ever had any of the following dental treatments?	❑ Orthodontics ❑ Root canal ❑ Periodontal ❑ Crowns or caps ❑ Bridgework ❑ Implant surgery ❑ Full or partial dentures

MEDICAL HISTORY

Does the patient generally feel anxiety, stress, or fear at the thought of going to the dentist?	❑ Never ❑ Sometimes ❑ Most of the time ❑ Always
Has the patient ever had an adverse reaction to, or does the patient have any allergies to any of the following substances?	❑ Local anesthetics / Novocain ❑ Codeine ❑ Aspirin / Advil ❑ Latex ❑ Sulfa ❑ Antibiotic _____ ❑ Other _____
Does the patient take any medications, vitamins, or supplements? If **YES,** please list below:	❑ Yes ❑ No

_____ _____

_____ _____

_____ _____

_____ _____

MEDICAL HISTORY (CON'T)

Is the patient a current tobacco user? ❑ Yes ❑ No If **YES**, frequency of use: _____ For how long? _____

Is the patient a previous tobacco user? ❑ Yes ❑ No If **YES**, how long ago did the patient quit? _____

FEMALES ONLY

Is the patient …	❑ Pregnant ❑ Nursing ❑ Taking birth control pills
Is the patient post-menopausal?	❑ Yes ❑ No
Does the patient have osteoporosis?	❑ Yes ❑ No
If **YES**, has the patient taken any of the following medications?	❑ Fosamax ❑ Fosamax Plus D ❑ Actonel ❑ Boniva ❑ Didronel ❑ Skelid ❑ Aredia ❑ Bonefos ❑ Zometa
If **NO**, has the patient ever been tested for osteoporosis?	❑ Yes ❑ No
Does the patient have any of the following risk factors for osteoporosis?	❑ Post-menopausal ❑ Early menopause ❑ Rheumatoid arthritis ❑ Family history of osteoporosis ❑ Tobacco use ❑ Inadequate exercise

MEDICAL CONDITIONS

Is the patient diabetic?	❑ Yes ❑ No
If **YES**, is diabetes control…	❑ Good ❑ Fair ❑ Poor
Name of patient's diabetes doctor:	_____
Date of last A1c (mm-dd-yyyy):	_____
Score:	_____
If **NO**, does the patient's family have a history of diabetes?	❑ Yes ❑ No
Has the patient experienced any of the following warning sign symptoms of diabetes?	❑ Frequent urination ❑ Excessive thirst / hunger ❑ Weakness / fatigue ❑ Slow healing of cuts ❑ Unexplained weight loss
Has the patient been diagnosed with heart disease/stroke?	❑ Yes ❑ No
If **NO**, does the patient have any of the following risk factors for heart disease?	❑ High cholesterol ❑ High blood pressure ❑ Family history of heart disease ❑ Tobacco use
Does the patient's family have a history of Alzheimer's Disease?	❑ Yes ❑ No
Does the patient's family have a history of gum disease?	❑ Yes ❑ No
Has the patient's spouse ever had, or does the patient's spouse have gum disease?	❑ Yes ❑ No
Has the patient ever had an organ transplant?	❑ Yes ❑ No
If **YES**, has the patient ever taken, or does the patient take any of the following medications?	❑ Dilantin ❑ Ca+ channel blockers ❑ Immunosuppressants
Has the patient ever been diagnosed with, or does the patient currently have any of the following medical conditions:	❑ Asthma ❑ Artificial joint(s) ❑ Autoimmune disorder(s) ❑ Bleeding problems ❑ Cancer ❑ Chemo / radiation therapy ❑ Chronic obstructive pulmonary disease ❑ Congestive heart failure ❑ Epilepsy ❑ Heart Arrhythmia ❑ Hepatitis ❑ HIV / AIDS ❑ Hypertension ❑ Kidney problems ❑ Liver condition ❑ Osteoporosis ❑ Poor nutrition ❑ Prosthetic heart valve ❑ Psychiatric therapy ❑ Rheumatoid arthritis ❑ Steroid use ❑ Stress ❑ Thyroid disease ❑ Tuberculosis ❑ Vertigo
Patient Signature: (Parent/Guardian signature if under 18 years of age)	_____
Dentist Signature:	_____