DENTAL CARE OF SALINA
HEATH HISTORY FORM

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be some additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: _____ SS#:_____ DOB: _____
If you are completing this form for another person, please list your name & relation to the patient:
Your Name: _____ Relationship to Patient: _____
Home Address: _____ City, State & Zip Code_____
Home/Cell Phone: _____ Business Phone: _____
Employer: _____ Position: _____
Primary Insurance Company: _____ Policy Holder: _____
Policy Holder DOB: _____ Relation to Pt: _____
Secondary Insurance Company: _____ Policy Holder: _____
Policy Holder DOB: _____ Relation to Pt: _____

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

Primary Care Physician & Phone Number: _____
Within the past year, have there been any changes in your general health? _____
_____
What is the approximate date of your last medical exam? _____
Y / N Have you had complications following dental treatment? _____
Y / N Are you under the care of a physician for a specific condition? If yes please list: _____
_____
Y / N Have you been hospitalized in the last 5 years? If yes please list:_____
_____
Y /N Do you use Tobacco? Circle: Smoking Chewing
Y / N Do you require corrective lenses? Circle: Glasses Contacts
Y / N Do you have any artificial joints? If yes please list location of joint, date of surgery & who performed the surgery: _____

WOMEN ONLY: Y / N Are you pregnant? If yes, please tell us your due date? _____

ALLERGIES TO (please circle): Penicillin Codeine Local Anesthesia Jewelry Latex/Rubber
Please list any other allergies:_____

If you are taking any medications please list them: _____
_____
_____
_____

Is there any additional information that you feel is important to tell us about your health (please list)?
_____
_____
_____

PLEASE CIRCLE YES OR NO TO THE FOLLOWING:

Y / N Abnormal bleeding	Y / N Alcohol Abuse	Y / N Allergies	Y / N Anemia
Y / N Angina	Y / N Artificial Joints	Y / N Asthma	Y / N Blood Disease
Y / N Cancer	Y / N Chemotherapy	Y / N Diabetes	Y / N Difficult Breathing
Y / N Dizziness	Y / N Emphysema	Y / N Epilepsy	Y / N Excessive Bleeding
Y / N Fainting	Y / N Glaucoma	Y / N Head Injuries	Y / N Heart Disease
Y / N Heart Murmur	Y / N Heart Surgery	Y / N Hemophilia	Y / N Hepatitis A
Y / N HIV	Y / N High Blood Pressure	Y / N High Cholesterol	Y / N Hepatitis B
Y / N Jaundice	Y / N Kidney Disease	Y / N Liver Disease	Y / N Hepatitis C
Y / N Mental Disorder	Y / N Mitrovalve Prolapse	Y / N Nervous Disorder	Y / N Osteoporosis
Y / N Pacemaker	Y / N Radiation Treatment	Y / N Respiratory Issues	Y / N Rheumatic Fever
Y / N Rheumatism	Y / N Sinus Issues	Y / N Stomach Issues	Y / N Stroke
Y / N Tuberculosis	Y / N Ulcers	Y / N Low Blood Pressure	

PLEASE CIRCLE YES OR NO TO THE FOLLOWING:

Y / N Bleeding Gums	Y / N Food Traps	Y / N Loose Teeth	Y / N Bad Breath
Y / N Swollen Gums	Y / N Broken Teeth	Y / N Missing Teeth	Y / N Loose/Lost Fillings
Y / N Frequent Cavities	Y / N Partials/Dentures	Y / N TMJ Problems	Y / N Popping/Clicking Jaws
Y / N Grinding Teeth	Y / N Headaches	Y / N Wear on Teeth	Y / N Gum treatments
Y / N Braces	Y / N Snore Regularly	Y / N Sores in the Mouth	

What Dentist have you seen most recently? _____ Approx. date? _____
What is the main reason for your visit today? _____
How do you feel about the appearance of your smile? _____

Is there any additional information that you feel is important to tell us about your dental health (please list)? _____
_____

AUTHORIZATION:
I understand that I am responsible for any balance for services that are not covered by my insurance, and I may be billed for the remaining balance. I consent & agree that I am responsible for payment of all services rendered on my behalf & on behalf of my dependents (if any).
I authorize this office to release information including diagnosis and records of treatment for myself and my dependent(s) to my insurance carriers, payers, and/or my healthcare practitioners. I authorize the payment from my insurance carrier to submit directly to this office and applied directly to my account.
As a condition of treatment, financial arrangements will be made in advance. Financial responsibility on the part of each patient will be determined prior to treatment.
A finance charge of 18% can be applied to any account that is 60 days past due, unless previous arrangements have been made.

I grant permission for this office to contact me by phone to discuss my account or my treatment.

Signature of Patient (or representative: _____ Date: _____
Relationship to Patient: _____