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CONFIDENTIAL HEALTH HISTORY

Today's Date: ___/___/___

Name_____Social Security No._____

Address_____ City _____State _____Zip_____

Birthdate: ___/___/_____ Home phone (_____) _____ Work Phone (____) _____Cell Phone (____)_____

If Patient is a minor, Parent's name_____SSN#_____Email_____

Where are you employed? _____Occupation_____

In case of emergency, whom should we contact? _____ Phone_____

Medical Physician's name _____Phone (_____)_____

Have you had any medical care withing the past two years?..... Yes No

Describe_____

Please list your current medications (name and dosage):_____

_____

_____

1. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs?..... Yes No
2. Are you aware of having an allergic **(or adverse)** reaction to any substance or medication?..... Yes No
   If yes please specify _____
3. Have you been a patient in the hospital during the past five years?..... Yes No
4. Do you have or have you had any disease, condition, or problem not listed?..... Yes No
   If yes please list _____
5. Are you addicted to, or, recovering from drugs or alcohol?..... Yes No
6. **Women**: Are you pregnant or think you could be pregnant? Yes _____Months No
7. Do you use birth control prescriptions? Yes No
8. Have you lost or gained more than 10 pounds in the past year? ..... Yes No
9. Indicate which of the following you have had or have at present. Circle **"yes"** or **"no"** to each item.

Heart (surgery Disease or Attack....	Yes	No	Ulcers.....	Yes	No	Hepatitis A B C (circle).....	Yes	No
Chest Pain.....	Yes	No	Diabetes.....	Yes	No	A.I.D.S./H.I.V. Positive.....	Yes	No
Congenital Heart Disease.....	Yes	No	Thyroid Problems.....	Yes	No	Cold Sores/Fever Blisters.....	Yes	No
Heart Murmur.....	Yes	No	Emphysema.....	Yes	No	Bruise Easily	Yes	No
High/Low Blood Pressure.....	Yes	No	Chronic Cough.....	Yes	No	Liver Disease/Yellow Jaundice	Yes	No
Mitral Valve Prolapse.....	Yes	No	Asthma	Yes	No	Neurological Disorders	Yes	No
Artificial Heart Valve/Pacemaker...	Yes	No	Hay Fever/Allergy/Hives.....	Yes	No	Epilepsy or Seizures	Yes	No
Arthritis/Rheumatism	Yes	No	Latex Sensitivity	Yes	No	Fainting or Dizzy Spells	Yes	No
Cortisone Medicine	Yes	No	Sinus Trouble	Yes	No	Nervous/Anxious ....., ...	Yes	No
Swollen Ankles	Yes	No	Radiation Therapy	Yes	No	Psychiatric/ Psychological Care	Yes	No
Stroke	Yes	No	Chemotherapy	Yes	No	Injectable Drugs	Yes	No
Kidney Trouble?	Yes	No	Cancer or Tumors	Yes	No	Medical Marijuana.....	Yes	No
Smoke/Chew tobacco, vaping or Use other tobacco products?.....	Yes	No	Artificial Joints (hip, knee, etc?)	Yes	No	Date of surgery for joint replacement _____		

How often do you brush your teeth? _____ How often do you floss? _____

History Review

Dentist Signature _____ Date ____/_____/_____

PLEASE TURN OVER

Have you ever used or are currently using topical fluoride? Yes No

What other dental aids do you use? (Waterpik, toothpick, etc.) _____

Do you have any dental problems now? Yes No

If yes, please describe _____

Are any of your teeth sensitive to:		
Hot or cold?	Yes	No
Sweets?	Yes	No
Bititng or Chewing?	Yes	No
Have you noticed any mouth odors or bad taste?	Yes	No
Do you frequently get cold sores, blisters or any	Yes	No
Do your gums bleed or hurt?	Yes	No
Have your parents experienced gum disease or	Yes	No
Have you noticed any loose teeth or change in your	Yes	No
Does food tend to become caught in between your	Yes	No

If yes, where? _____

Do you:		
Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth?	Yes	No
(pencils, pipes, pins, nails, fingernails)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Snore, wear a C-PAP, sleeping disorders?	Yes	No
Smoke/chew tobacco, vaping, or use other tobacco products?	Yes	No

How long and what type? _____

Have you ever had:		
Orthodontic Treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal Treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

If so, please describe, including cause_____

_____

Have you experienced?		
Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face?)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neck or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No
Are you satisfied with your teeth's appearance?	Yes	No
Would you like to keep all of your teeth all of your	Yes	No
Do you feel nervous about having dental	Yes	No

If so, what is your biggest concern?

_____

Have you ever had an upsetting dental experience?	Yes	No

What?_____

_____

Have you ever been told to take a pre-medication prior to dental treatment?	Yes	No
Is there anything else about having dental treatment that you would like us to know?	Yes	No

If yes, please describe _____

HIPAA Office Information

By signing this form, I acknowledge that I am aware that this office's **Notice of Privacy Practice** is available to me at the front desk and my signature constitutes acknowledgement of such policy. I am free to ask any questions.

Consent to Contact Consumer

You agree, in order for us to service your account or to collect monies you may owe, Dr. Freedman and/or our agents may contact you by telephone at any number associated with your account, including wireless via number, text or email (if address was provided), which could result in charges to you. Methods of contact may include pre-recorded/artificial voice messages and/or automatic dialing device, as applicable. I/We have read this disclosure and agree that Dr. Freedman, employees, and/or agents may contact me/us as described above.

Consent to Treatment

To the best of my knowledge, all preceding answers are true and correct. If anything, ever changes, I will inform the Doctor at the next appointment. I am also aware that there are inherent risks in all dental procedures, including administration of anesthesia (Novocaine) and the use of Nitrous Oxide (if so indicated). I give the doctor and his/her staff permission to perform dental procedures on me or my dependent or guardian. I also understand that I am free to ask questions regarding the procedure or risks involved.

Patient's Signature _____Witness _____Date_____/_____/_____

If signing for a minor, your relationship to the minor _____

If someone else is filling this form out for the patient, your name _____