SHUMWAY DENTAL

Dental / Health History Form

Personal Information

Patient Name: _____
Last First MI

Address: _____
Street City State Zip

Date of Birth: _____

Cell / Phone Number: _____ Email: _____

Dental Insurance Information

Please Circle: Single / Married / Child

Carrier: _____ Employer: _____

Subscriber Name: _____ Subscriber Birth Date: _____

Subscriber Number: _____ Group Number: _____

If no subscriber number given, please list social security number: _____

Do you have any Medicaid or State – Sponsored Insurance Plan? YES NO

If yes, please describe: _____

Emergency Contact Information

Name: _____ Relationship: _____ Phone: _____

Dental History

Date of last cleaning: _____

Date of last dental x-rays: _____

Why are you seeking treatment? _____

_____

Currently, do you have: sensitive teeth, toothaches, infections, or other dental concerns?

_____

_____

YES	NO	Surgery: Periodontal (gum), Jaw, Implants, or Extractions
YES	NO	Does going to the dentist make you nervous?
YES	NO	Dry mouth
YES	NO	Jaw joint problems *(TMJ, Difficulty opening, clench or grind teeth)*
YES	NO	Oral Habits *(Thumb sucking, nail, or object biting)*
YES	NO	Accidental Injuries to teeth, mouth, or jaw
YES	NO	Orthodontic Treatment *(braces, Invisalign)*
YES	NO	Have you used nitrous oxide (laughing gas) before?

Health History

1. YES NO Any Allergies (Drug, Medications, Latex, Iodine, Nuts, Environmental, etc.)?

   Please list type and reaction below.

   _____

   _____

2. YES NO Have you had any outpatient surgery or been hospitalized within the last five years?

   _____

3. YES NO Are you taking any prescription or non – prescriptions drugs or medications?

   _____

   _____

   _____

   _____

4. YES NO Are you in generally good health?

5. YES NO Are you under the care of a physician?

   Physicians Name: _____ Date of Last Physical: _____

YES	NO	Have you ever been told that you need antibiotic premedication before dental procedures?
YES	NO	Are you aware of any health condition which you have chosen not to seek treatment?
YES	NO	(FEMALE) Pregnant If yes, due date? _____
YES	NO	Heart Disease *(Chest Pains, Heart Attack, Congestive Heart Failure*)
YES	NO	Heart Defect *(Rheumatic Fever, Mitral Valve Prolapse, Heart Murmur)*
YES	NO	Heart Surgery *(Artificial Heart Valve, Cardiac Stent, Pacemaker)*
YES	NO	High or Low Blood Pressure BP: _____
YES	NO	Stroke If yes, when? _____
YES	NO	Blood Thinners
YES	NO	Abnormal Bleeding
YES	NO	Arthritis / Rheumatoid Conditions
YES	NO	Artificial Joint *(Knee, Hip)* or Artificial Pin / Screws / Plates
YES	NO	Respiratory Issues *(Frequent cough, Sinus Trouble, Asthma, Emphysema, Tuberculosis)*
YES	NO	Lung Disease
YES	NO	Liver Disease / Hepatitis *(Jaundice)*
YES	NO	Kidney Problems
YES	NO	Organ Transplant / Blood Transfusion
YES	NO	Cancer *(Specify type and location)* _____ Radiation Therapy / Chemotherapy
YES	NO	Diabetes If yes, type? _____
YES	NO	Neurological Disorder *(Epilepsy, Seizures, Multiple Sclerosis, Parkinson's Disease)*

YES	NO	Emotional / Anxiety Disorder			
YES	NO	Thyroid Condition			
YES	NO	History of Osteoporosis (*Infusions*)			
YES	NO	Venereal Disease, Herpes			
YES	NO	HIV Positive, AIDS			
YES	NO	Gastrointestinal Issues *(Crohn's Disease, Ulcerative Colitis)*			
YES	NO	Acid Reflux / Heartburn			
YES	NO	Cold Sore / Canker Sore			
YES	NO	Unintentional Weight Loss			
YES	NO	Significant Hearing Impairment, Visual Impairment			
YES	NO	Chronic Headaches or Migraines			
YES	NO	Fainting			
YES	NO	Tobacco Use *(Smoking, Smokeless, Vaping)*	Never	Former	Current
YES	NO	Recreational Drug Use			
YES	NO	Do you or have you experienced: drug, alcohol, or substance abuse			

Patient Authorization and Release

To my knowledge all of the information on this history form is correct. Your answers are for our records only and will be kept confidential in accordance with applicable laws. I understand that by signing this I am giving my consent to dental treatment. I understand that if any change occurs in my heath during my series of appointments as a patient, I am to report it to the dental provider providing my dental treatment.

_____ _____

Signature of Patient, Parent or Guardian Date

_____ _____

Doctor Signature Date

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