

PERSONAL INFORMATION - HEALTH HISTORY

THE CENTER FOR IDEAL DENTISTRY

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NAME _____ BIRTHDATE: _____

MAILING ADDRESS _____

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

WHO REFERRED YOU TO OUR OFFICE? _____

PHONES: Work: _____ Home: _____ FAX: _____

Cell: _____ Pager: _____ E-mail: _____

OCCUPATION: _____ EMPLOYER & address _____

Spouse's OCCUPATION _____ EMPLOYER & address _____

ACCOUNT RESPONSIBILITY if someone other than yourself: NAME _____

BIRTHDATE: _____ MAILING ADDRESS: _____

INSURANCE: We will provide you with your completed insurance form that you can then send into your insurance company. You will receive a reimbursement directly for whatever you are entitled to. **The most important thing for you to know is the amount of your "calendar year maximum" which you can find by calling your insurance carrier.**

HEALTH HISTORY (Have you ever had any of the following, please check YES or NO. If yes, please circle one if multiple options.)

<input type="checkbox"/> Yes <input type="checkbox"/> No Are you in good health	<input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes
<input type="checkbox"/> Yes <input type="checkbox"/> No Has your health changed in the last year	<input type="checkbox"/> Yes <input type="checkbox"/> No Tumors or Cancer
<input type="checkbox"/> Yes <input type="checkbox"/> No Chest Pain or Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No Radiation / Chemotherapy
<input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding Problems or Bruise Easily	<input type="checkbox"/> Yes <input type="checkbox"/> No Psychiatric Care
<input type="checkbox"/> Yes <input type="checkbox"/> No Blood Thinners / Cumadin	<input type="checkbox"/> Yes <input type="checkbox"/> No Kidney or Bladder Disease
<input type="checkbox"/> Yes <input type="checkbox"/> No Headaches or Ringing in Ears	<input type="checkbox"/> Yes <input type="checkbox"/> No VD, Herpes
<input type="checkbox"/> Yes <input type="checkbox"/> No Joint Replacement	<input type="checkbox"/> Yes <input type="checkbox"/> No HIV positive, AIDS, ARC
<input type="checkbox"/> Yes <input type="checkbox"/> No Fainting or Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No Now Pregnant: Month _____
<input type="checkbox"/> Yes <input type="checkbox"/> No Heart Disease, Murmurs, Rheumatic Fever or Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No Birth Control Pills
<input type="checkbox"/> Yes <input type="checkbox"/> No Pacemaker or Prosthetic Heart Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No Acid Reflux
<input type="checkbox"/> Yes <input type="checkbox"/> No Osteoporosis or Osteopenia	<input type="checkbox"/> Yes <input type="checkbox"/> No Problem with Dry Mouth
<input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No Recreational Drugs
<input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis or Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No Smoking or Alcohol
<input type="checkbox"/> Yes <input type="checkbox"/> No Latex Allergy	
<input type="checkbox"/> Yes <input type="checkbox"/> No Asthma, TB or Lung Disease	

List any and all **DRUG ALLERGIES**, include over the counter medications: _____

List any and all **DRUGS/MEDICATIONS/HERBS/SUPPLEMENTS** you are taking: _____

List any and all **SURGERIES**: _____

Are you being treated by a Doctor now? No Yes If yes, who? _____

The above information is true and correct to the best of my knowledge.

PATIENT SIGNATURE: _____ DATE: _____

PHOTO RELEASE:

I give The Center for Ideal Dentistry authorization to use my photograph in the dental office, practice newsletter, brochure, and website.

PATIENT SIGNATURE: _____ DATE: _____