

**HEALTH HISTORY UPDATE**  
**THE CENTER FOR IDEAL DENTISTRY**  
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NAME \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

MAILING ADDRESS (IF NEW): \_\_\_\_\_

PHONES: Work: \_\_\_\_\_ Home: \_\_\_\_\_ FAX: \_\_\_\_\_

Cell #: \_\_\_\_\_ Pager: \_\_\_\_\_ E-mail: \_\_\_\_\_

Would you like to hear about options to improve your smile?     YES     NO

**INSURANCE:** If you have dental insurance, we will provide you with your completed insurance form, which you can then send to 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    Asthma, TB or Lung Disease
<input type="checkbox"/> Yes <input type="checkbox"/> No    Has your health changed in the last year	<input type="checkbox"/> Yes <input type="checkbox"/> No    Diabetes
<input type="checkbox"/> Yes <input type="checkbox"/> No    Chest Pain or Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No    Tumors or Cancer
<input type="checkbox"/> Yes <input type="checkbox"/> No    Bleeding Problems or Bruise Easily	<input type="checkbox"/> Yes <input type="checkbox"/> No    Radiation / Chemotherapy
<input type="checkbox"/> Yes <input type="checkbox"/> No    Blood Thinners / Cumadin	<input type="checkbox"/> Yes <input type="checkbox"/> No    Psychiatric Care
<input type="checkbox"/> Yes <input type="checkbox"/> No    Headaches or Ringing in Ears	<input type="checkbox"/> Yes <input type="checkbox"/> No    Kidney or Bladder Disease
<input type="checkbox"/> Yes <input type="checkbox"/> No    Joint Replacement	<input type="checkbox"/> Yes <input type="checkbox"/> No    VD, Herpes
<input type="checkbox"/> Yes <input type="checkbox"/> No    Fainting or Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No    HIV positive, AIDS, ARC
<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    Now pregnant: Month _____
<input type="checkbox"/> Yes <input type="checkbox"/> No    Pacemaker or Prosthetic Heart Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No    Birth Control Pills
<input type="checkbox"/> Yes <input type="checkbox"/> No    Osteoporosis or Osteopenia	<input type="checkbox"/> Yes <input type="checkbox"/> No    Acid Reflux
<input type="checkbox"/> Yes <input type="checkbox"/> No    High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No    Problem with Dry Mouth
<input type="checkbox"/> Yes <input type="checkbox"/> No    Hepatitis or Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No    Recreational Drugs
<input type="checkbox"/> Yes <input type="checkbox"/> No    Latex Allergy	<input type="checkbox"/> Yes <input type="checkbox"/> No    Smoking / Alcohol

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: \_\_\_\_\_