Hamann Dentistry's Health History Form

Patient Information

Patient Name: ____ Date: _______________________

E-Mail Address: ____________________________________ ☐ Male ☐ Female ☐ Married ☐ Single ☐ Child

Social Security Number: ______________ Birth Date: ____________

Phone (Home): ___________________ (Work): ___________________ Ext: _______ (Cell): _______________________

Address: ____
Street Apt. #

____
City State Zip code

Preferred Method of Confirming Appointments: ☐ Phone Call ☐ Email ☐ Text (standard rates apply) **Carrier** _________

Referral Information

Whom may we thank for referring you to our practice?

☐ Another patient, friend: ___________________ ☐ Another patient, relative: ___________________

☐ Yellow Pages/Phone Book ☐ Newspaper ☐ Work ☐ Website ☐ Insurance ☐ Location

☐ Employee of Hamann Family Dentistry: ________________ ☐ Other: _________________________

Employment Information

Employer Name: _____________________________ Occupation: _______________________________

Emergency Contact Information

Name: _________________________ Relationship to patient: _________________ Phone: _______________

If a Minor, Parent/Guardian Information

Name:____________________________________ Relationship to patient:_________________________

Address:____ Phone Number:_______________

Dental Insurance? If yes, please bring your card to receptionist.

CONTINUE TO BACK

Health Information

Date of Last Dental Visit: ______________________ Reason for Visit: ________________________________

Have you ever had any of the following? Please check those that apply:

☐ AIDS
☐ Allergies
- Codeine
- Penicillin
- Local Anesthetic
- Sulfa Drug
- Metals
- Other: ____________

☐ Abnormal Bleeding
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Chemotherapy
☐ Diabetes
- Type I
- Type II

☐ Dizziness
☐ Eating Disorder
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ G.E. Reflux
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Attack
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Osteoporosis
☐ Pace Maker
☐ Pregnancy
Due Date:___________
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatism
☐ Seizures/Fainting Spells
☐ Sinus Problems
☐ Stomach problems
☐ Stroke
☐ Tuberculosis (TB)
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Other:
____
____
____
____
____
☐ Current Medications:
____
____
____

Have you ever had complications following a dental treatment? ☐ Yes ☐ No
If yes, please explain: ____

Are you under the care of a physician? ☐ Yes ☐ No
If yes, physician's name: _________________________________ Phone: ______________________

Have you been admitted to a hospital or needed emergency care during the past two year? ☐ Yes ☐ No
If yes, please explain: ____

Have you had an orthopedic total joint (hip, knee, elbow) replacement? ☐ Yes ☐ No
If yes, any complications? ____________________ Date: ______________________

Are you taking or schedule to take either alendronate (Fosamax) or risedronate (Actonel) for osteoporosis?
☐ Yes ☐ No

Are you taking or presently schedules to begin treatment with the intravenous bisphosphonates (Aredia or Zometa)?
☐ Yes, date treatment began: ______________________ ☐ No

Are you currently taking any medication that is a blood thinner? ☐ Yes ☐ No
Name of Medication: ______________________________ Start Date: _____________________

Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain: ____

Do you smoke? ☐ Yes ☐ No Do you chew tobacco? ☐ Yes ☐ No

I certify that I have read and understood the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I will not hold my dentist, or any other members of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. If changes in my health, I will inform the doctors.

Signature of patient: ____ Date: _____________________