SALEM CREEK
FAMILY DENTISTRY

Health History Form

Patient Information

Date: _____

Patient: _____

Address:_____

_____

City State Zip Code

Sex: _____ Age: _____ Birthdate: _____ Patient SSN: _____

Phone- Home: _____ Cell: _____

Work: _____ Best time to call you: _____

Email Address: _____

Employer: _____ Employer Phone: _____

Employer Address: _____

Whom may we thank for referring you to our office? _____

Dental Insurance

****Hand us your insurance card. ****

~Only fill out this section if you do NOT have your card.~

Who is responsible for this account? _____

Relationship to patient: _____

Insurance Co: _____ Ins. Phone #: _____

Member ID: _____

Group #: _____ Is patient covered by additional insurance? _____

Subscriber's Name: _____ Birthdate: _____ SSN: _____

Relationship to Patient: _____

Insurance Co: _____ Group #: _____

Assignment and Release: I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Bartlett all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Responsible Party Signature Relationship Date

Dental History

Reason for today's visit: _____

Former Dentist: _____ City/State: _____

Date of last dental visit: _____ Date of last dental X-rays: _____

Check any that apply:

General Dental Questions

☐ Do you have dental Anxiety?
If yes, please talk to us about it so we can help!

☐ Bleeding gums

☐ Gums swollen or tender

☐ Cigarette, pipe, smoking or vaping

☐ Loose teeth

☐ Broken fillings

☐ Sensitivity to biting

☐ Sensitivity to cold

☐ Sensitivity to hot

☐ Sensitivity to sweets

☐ Would you like whiter teeth?

Clenching and Grinding Questions

☐ Do you ever wake up with sore chewing muscles?

☐ Is it ever sore to chew shortly after you wake up?

☐ Are your teeth ever sensitive in the mornings?

☐ Do you have pain in your jaw joint? (front jaw)

☐ Has your jaw ever locked open or closed?

Dry Mouth Questions

☐ Do you feel that you have dry mouth?

☐ Do you need to take frequent sips of water to moisten your mouth?

☐ Do you need to drink when eating a sandwich or similar food?

Sleep Apnea Questions

☐ Do you often feel tired, fatigued, or sleepy during the daytime?

☐ Do you snore?

☐ Has anyone ever seen you stop breathing when you are asleep?

Medical History

Physician's Name: _____ Date of last visit: _____

Check any that apply:

Heart (Cardiac) Health	**Breathing (Respiratory) Health**	**Digestive Health**
☐ Pacemaker/Implanted defibrillator	☐ Asthma (COPD)	☐ Gastrointestinal disease
☐ Heart Valve Repair with prosthetic materials	☐ Emphysema	☐ G.E. reflux/persistent heartburn GERD
☐ Heart transplant with regurgitation		☐ Stomach ulcers
☐ Previous infective endocarditis	☐ **Cancer**	
☐ Congenital heart disease (CHD)	Type	**Eye (Vision) Health**
Unrepaired, cyanotic CHD	Date of diagnosis	☐ Glaucoma
Repaired (completely) in last 6 months	☐ Chemotherapy	
Repaired CHD with residual defects	☐ Radiation treatment	**Other**
☐ Arteriosclerosis		☐ Diabetes (type I or II)
☐ Coronary artery disease	**Blood (Circulatory) Health**	☐ Hepatitis, jaundice or liver disease
☐ Congestive heart failure	☐ Hemophilia (Blood clotting issue)	☐ Immune deficiency
☐ Damaged heart valves	☐ High or low blood pressure	☐ Kidney problems
☐ Heart attack		☐ Osteoporosis
☐ Heart murmur/rhythm disorder	**Mental Health**	☐ Thyroid problems
☐ Rheumatic heart disease	☐ Anxiety	☐ AIDS or HIV infection
☐ Stroke	☐ Depression	☐ Parkinson's disease
	☐ Epilepsy	☐ Had a Joint Replacement
	☐ Mental health disorders	

Medications

☐ Have you ever taken a Bisphosphonate or Antiresorptive drug? (usually for osteoporosis or some cancers.) Examples include alendronate (Fosamax) zoledronic acid (Reclast, Zometa, Aclasta) risedronate (Actonel), Altelvia, Didronel, Boniva, Prolia

If yes, was it in pill form or IV? (circle)

List any medications you are currently taking: _____ _____

*****Feel free to give us a list so we can make a photocopy so you don't have to fill this out*** _____ _____

_____ _____

_____ _____

Allergies

☐ Penicillin ☐ Codeine Other _____

☐ Cephalexin ☐ Local Anesthetic _____

☐ Aspirin ☐ Latex _____

Signature _____