Adult Health History

Dr. Weeks & Associates

Patient Name: Preferred Nickname to be called:

LAST FIRST MIDDLE INITIAL

Sex: ☐ M ☐ F

Marital Status: ☐ Single ☐ Married ☐ Other

Date of Birth: / /

Social Security #: - -

Mailing Address: City: State: Zip:

Employer: Home Phone #: ( ) – Work Phone #: ( ) – Cell Phone #: ( ) –

Email Address (*PLEASE PRINT CLEARLY*): Spouse Name: Spouse Social Security #: - -

How did you hear about us?

☐ Advertisement ☐ Phone Book ☐ Internet ☐ Office Sign ☐ Other: ______

☐ Another patient - Please list their name so we may thank them: ______

Insurance Information

Primary Insurance Company: ______	Secondary Insurance Company: ______
Subscriber Name:	Subscriber Name:
Subscriber Social Security #: - -	Subscriber Social Security #: - -
Subscriber Date of Birth: / /	Subscriber Date of Birth: / /
Employer:	Employer:
Group #:	Group #:
Member ID #:	Member ID #:
Insurance Phone #: ( ) –	Insurance Phone #: ( ) –

Dental Information

Question	YES	NO
Have you ever experienced complications with any dental treatment?	☐	☐
Do you need any help overcoming fear of having dental treatment?	☐	☐
Are you interested in being sedated for any dental work you may need?	☐	☐
Does food regularly wedge or get caught between your teeth?	☐	☐
Are any teeth sensitive to hot, cold, sweets, or the pressure of biting down?	☐	☐
Are you currently experiencing dental pain or discomfort?	☐	☐
Do your gums ever bleed when you brush or floss?	☐	☐
Have you ever been treated for gum disease?	☐	☐
Have you ever worn braces or received orthodontic treatment?	☐	☐
Do you clench or grind your teeth (especially when sleeping)?	☐	☐
Have you ever had an injury to your face, head, or neck?	☐	☐
Do you have any clicking, popping, or discomfort in the jaw?	☐	☐
Do you presently wear any partials or dentures?	☐	☐
Do you ever feel like you have dry mouth?	☐	☐

Approximate date and reason of your last dental visit: / /

Approximate date of your last dental x-rays? / /

If you had a magic wand, what *(if anything)* would you change about your smile?

Medical Information

Question	YES	NO
Are you in good health?	☐	☐
Are you currently under the care of a physician?	☐	☐
Are you pregnant or nursing?	☐	☐
Have you ever had surgery, radiation, or other treatment for a tumor or growth?	☐	☐
Has there been any change in your general health within the past year?	☐	☐
Have you been hospitalized or had a serious illness within the past 5 years?	☐	☐

If you are pregnant, what is your due date? / /

If yes, what for?

List in case of emergency contact name and their phone number:

>>> CONTINUED ON BACK <<<

Medical Information

If you have or ever had any of the following, please check any that apply:

☐ AIDS / HIV	☐ Coronary Artery Disease	☐ High Blood Pressure	☐ Osteoporosis
☐ Allergies (Other than medications)	☐ Damaged Heart Valves	☐ Jaundice	☐ Pacemaker
☐ Anemia	☐ Diabetes or Hypoglycemia	☐ Joint Replacement (Hip, knee, or other)	☐ Polio
☐ Angina (Chest pains)	☐ Emphysema	☐ Kidney Problems or Disease	☐ Respiratory Problems
☐ Arthritis	☐ Excessive or Abnormal Bleeding	☐ Leukemia	☐ Rheumatic Fever
☐ Asthma or Hay Fever	☐ Fainting Spells, Convulsions, or Epilepsy	☐ Liver Disease	☐ Severe Coughing
☐ Autism / Aspergers	☐ Fibromyalgia	☐ Low Blood Pressure	☐ Sinus Trouble
☐ Atherosclerosis	☐ Glaucoma	☐ Lung Disease	☐ Sleep Disorder or Apnea
☐ Blood Disease	☐ Heart Attack or Disease	☐ Mental Health or Nervous Disorder	☐ Stomach or Intestinal Disorders
☐ Cancer	☐ Heart Murmur	☐ Mitral Valve Prolapse	☐ Stroke
☐ Congenital Heart Defects	☐ Heart Surgery or Heart Valve Surgery	☐ MRSA	☐ Thyroid Problems
☐ Congestive Heart Failure	☐ Hepatitis	☐ Organ Transplant	☐ Tuberculosis

Do you have any disease, condition, or problem not listed above that Dr. Weeks should know about? Please explain:

If you are allergic or have had an unusual reaction to any of the following medications, please check any that apply:

☐ Aspirin	☐ Erythromycin	☐ Metals	☐ Sedatives or Sleeping Pills
☐ Barbiturates	☐ Iodine	☐ Nitrous Oxide	☐ Sulfa Drugs
☐ Codeine	☐ Latex	☐ Novocain	☐ Xylocaine
☐ Epinephrine	☐ Local Anesthetic	☐ Penicillin	☐ Any other drug allergies: ____________________

YES	NO	
☐	☐	Have you ever been advised not to take a particular medication(s)? If YES please list the medication(s): ____________________
☐	☐	Have you ever taken or are you taking medication(s) for osteoporosis (such as Fosamax or Actonel)?
☐	☐	Have you ever received intravenous bisphosphonates (such as Aredia or Zometa) for bone pain, hypercalcemia, or skeletal complications?
☐	☐	Have you ever been advised to take antibiotics before dental cleanings or treatment?
☐	☐	Do you use tobacco (smoking, snuff, chew, etc…)? If YES, are you interested in stopping? ***(CIRCLE ONE)*** VERY / SOMEWHAT / NOT INTERESTED
☐	☐	Do you drink alcoholic beverages? If YES, how many drinks per day: ____________________
☐	☐	Do you take "Recreational" drugs such as cocaine, marijuana, stimulants, or depressants that may have a fatal interaction with local anesthetics or other common dental medications? Please describe the use of any drugs or discuss in complete confidentiality with the doctor.

IMPORTANT

PLEASE LIST ALL THE PRESCRIPTION AND OVER THE COUNTER MEDICATIONS you are taking *(Include the frequency taken).*

Also list any vitamins, natural or herbal preparations, and/or diet supplements.

To the best of my knowledge, all the preceding answers are true and correct. If I have any change in my health or medications, I will inform the doctor at my next appointment. I understand the importance of a truthful health history and that my dentist and his staff will rely on this information for treating me. If deemed advisable, I grant permission for my physician to be contacted for details and advice. I further authorize the taking of radiographs, photographs, or other diagnostic measures appropriate for a thorough evaluation. Authorization is also given for dental treatment to be rendered by the dentist and office staff and I will assume financial responsibility. Occasionally my photographs, x-rays or models may be used to educate another patient about a condition or procedure. My identity will not be divulged when displaying or sharing these photographs, x-rays or models. I have denoted below if my permission is not given to use my photographs, x-rays or models in this manner. Any account balance 90 days or older will be assessed a finance charge of 18% APR. Any returned checks are subject to a $30.00 fee. In the event it should be necessary to place your account in the hands of an attorney or collection agency, you will be responsible to pay all costs of collection, including collection company and attorney's fees.

Signature: ______________________________ **Date:** ____________________

Our office is HIPAA compliant and is committed to meeting and exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.