Valley Dental Center

Health History Form

Patient's E-mail: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you and your child that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning the health of your child. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Patient's Name (LAST / FIRST / MIDDLE INITIAL) Home Phone Work/Cell Phone

Address City State Zip

Occupation: Height Weight Date of Birth Sex: M ☐ F ☐

SS# or Patient ID Emergency Contact Relationship Cell Phone

If you are completing this form for another person, what is your relationship to that person?

Your Name Relationship

Do you have any of the following diseases or problems: **(Check 'DK' if you Don't Know the answer to the question)**	**Yes**	**No**
Active Tuberculosis	☐	☐
Persistent cough greater than a 3 week duration	☐	☐
Cough that produces blood	☐	☐
Been exposed to anyone with tuberculosis	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information

Please mark (X) as your responses to the following questions.

	Yes	**No**
Do your gums bleed when you brush or floss?	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐
Does food or floss catch between your teeth?	☐	☐
Is your mouth dry?	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐
Is your home water supply fluoridated?	☐	☐
Do you drink bottled or filtered water?	☐	☐
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY		
Are you currently experiencing dental pain or discomfort?	☐	☐

	Yes	**No**
Do you have earaches or neck pains?	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐
Do you brux or grind your teeth?	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐
Do you wear dentures or partials?	☐	☐
Do you participate in active recreational activities?	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information

Please mark (X) as your responses if you have or have not had any of the following diseases or problems.

	Yes	**No**
Are you now under the care of a physician?	☐	☐

Physician Name: Phone:

Address/City/State/Zip:

Are you in good health?	☐	☐
Any change in your general health within the past year?	☐	☐

If yes, what condition is being treated?

	Yes	**No**
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐

If yes, what was the illness or problem?

Are you taking or recently taken any prescription or over the counter medicine(s)?	☐	☐

Please list all, including vitamins, natural/herbal and/or diet supplements:

Date of your last physical exam:

Medical Information

Please mark (X) as your responses to indicate if you have or have not any of the following diseases or problems.

	Yes	No
Do you wear contact lenses	☐	☐
Are you taking, or have taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)?	☐	☐
Are you taking, or scheduled to begin taking either of the medications, alendronate (Fosamaxz®) or risedronate (Actonel®) for osteoporosis or Paget's disease?	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐
Date treatment began? _____		

	Yes	No
Do you use controlled substances (drugs)?	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis?	☐	☐
If yes, how interested are you in stopping? ☐ Very ☐ Somewhat ☐ Not Interested		
Do you drink alcoholic beverage	☐	☐
If yes, how much did you drink in the last 24 hours? _____		
If yes, how much did you drink in a week? _____		

For Women Only – Are you:

Pregnant	☐	☐
Number of weeks _____		
Taking birth control pills or hormonal replacement	☐	☐
Are you currently nursing	☐	☐

Joint Replacement – Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ☐ ☐

Date _____ If yes, have you had any complications? _____

Allergies – Are you allergic to or have you had a reaction the following? To all **yes** responses, specify type of reaction.

	Yes	No		Yes	No
Local Anesthetics _____	☐	☐	Metals _____	☐	☐
Aspirin _____	☐	☐	Latex (Rubber) _____	☐	☐
Penicillin or other Antibiotics _____	☐	☐	Iodine _____	☐	☐
Barbiturates, Sedatives, or Sleeping Pills _____	☐	☐	Hay Fever / Seasonal _____	☐	☐
Sulfa Drugs _____	☐	☐	Animals _____	☐	☐
Codeine or other Narcotics _____	☐	☐	Other _____	☐	☐

Health Checklist

Please mark (X) as your responses to indicate if you have or have not any of the following diseases or problems.

	Yes	No		Yes	No		Yes	No		Yes	No
Heart Murmur	☐	☐	Anemia	☐	☐	Chronic Pain	☐	☐	Epilepsy	☐	☐
Mitral Valve Prolapse	☐	☐	Blood Transfusion	☐	☐	Cancer/Chemotherapy/			Fainting Spells or Seizures	☐	☐
Artificial Heart Valves	☐	☐	If yes, date: _____			Radiation Treatment	☐	☐	Neurological Disorders	☐	☐
Rheumatic Fever	☐	☐	Hemophilia	☐	☐	Diabetes Type I or II	☐	☐	If Yes, Specify: _____		
			AIDS or HIV Infection	☐	☐	Eating Disorder	☐	☐	Sleep Disorder	☐	☐
Cardiovascular Disease	☐	☐	Arthritis	☐	☐	Malnutrition	☐	☐	Mental Health Disorders	☐	☐
Angina Arteriosclerosis	☐	☐	Autoimmune Disease	☐	☐	Gastrointestinal Disease	☐	☐	If Yes, Specify: _____		
Congestive Heart Failure	☐	☐	Rheumatoid Arthritis	☐	☐	G.E. Reflux/Persistent			Recurrent Infections	☐	☐
Coronary Artery Disease	☐	☐	Systemic Lupus			Heartburn	☐	☐	Specify Type: _____		
Damaged Heart Valves	☐	☐	Erythematosus	☐	☐	Ulcers	☐	☐	Kidney Problems	☐	☐
Heart Attack	☐	☐	Asthma	☐	☐	Thyroid Problems	☐	☐	Night Sweats	☐	☐
Low Blood Pressure	☐	☐	Bronchitis	☐	☐	High Blood Pressur	☐	☐	Osteoporosis	☐	☐
High Blood Pressure	☐	☐	Emphysema	☐	☐	Stroke	☐	☐	Persistent Swollen Glands	☐	☐
Congenital Heart Defects	☐	☐	Sinus Trouble	☐	☐	Glaucoma	☐	☐	in Neck	☐	☐
Pacemaker	☐	☐	Tuberculosis	☐	☐	Hepatitis, Jaundice or	☐	☐	Severe Headaches or	☐	☐
Rheumatic Heart Disease	☐	☐	Chest Pain on Exertion	☐	☐	Liver Disease	☐	☐	Migraines	☐	☐
Abnormal Bleeding	☐	☐	Severe Rapid Weight Loss	☐	☐	Sexually Transmitted Disease	☐	☐	Excessive Urination	☐	☐

Has a physician or dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐

Name of physician or dentist making recommendation _____ Phone _____

Do you have any disease, condition, or problem not listed above that you think I should know about? ☐ ☐

Please explain:

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand 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 acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member 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.

Signature of Patient / Legal Guardian _____ Date _____

For Comments - Completion by Dentist

For Office Use Only: ☐ Medical Alert ☐ Premedication ☐ Allergies ☐ Anesthesia Reviewed By _____ Date _____

Valley Dental Center

Cancellation and Broken Appointment Policy

We understand that illness, emergencies, car trouble and bad weather do occur. We ask our patients to give us 48 hours notice, whenever possible, if they're unable to keep an appointment. This allows us time to fill our schedule with other patients who may be waiting.

Policy:

- Cancellation or rescheduling of an appointment with 48 hours or more notification – no charge.
- We allow for one (1) broken appointment within a 12-month period without charge.

Definition of a "Broken Appointment":

- Cancel or reschedule a confirmed appointment with less than 24 hours notice or
- You do not show up for your confirmed scheduled appointment.
- You do not respond to our repeated attempts to confirm your appointment.

Fees:

At our discretion, cancellation or rescheduling of an appointment with less than 24 hours notification may be subject to a broken appointment fee of $50.00. Recurrent broken appointments within a 12-month period will be charged a fee of $50.00 each.

Our number one objective is your dental health. Providing services in a timely manner is critical to accomplishing our goal.

Additionally, we continually strive to keep the cost of your dental services as economical as possible. When you fail to keep an appointment without providing adequate notice, the broken appointment increases the overall cost of your care as trained professionals and the dental facilities are not being utilized.

We appreciate your understanding and consideration of our appointment policy.

Should you have any questions or require additional information, please do not hesitate to contact us.

I have read and agree to the above mentioned policy.

_____ _____

Patient signature (Parent or Guardian if minor) Date