ROSELAND FAMILY DENTAL

PATIENT HEALTH HISTORY

Today's Date		**Referred by**	
Previous Dentist		**Reason For Change**	
Family Doctor		**Doctor Phone**	
Specialist		**Specialist Phone**	

Patient registration details

Name		**Date Of Birth**	
Address		**Postal Code**	
Occupation		**Home Phone**	
Mobile Phone		**Work Phone**	
Email			

Emergency Contact

Name		**Relationship**	
Daytime Phone		**Mobile Phone**	

Insurance Details

Insured's name				**Date of Birth**	
Employer			**Home Phone**		
Address					
Primary Insurance Company Name					
Address					
Phone		**Insured's ID**		**Group #**	
Contact		**Contact's Phone**		**Claim #**	

Insurance Details

Secondary Insurance Company					
Address					
Phone		**Insured's ID**		**Group #**	
Contact		**Contact's Phone**		**Claim #**	

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by Doctor-Patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

Details	Yes	No	Not Sure
Are you being treated for any medical condition at this present time or have you been treated in the past year?	☐	☐	☐
If so, why?			
When was your last medical check up?			
Has there been any change in your general health in the past year?	☐	☐	☐
If yes, explain:			
Are you taking medications, non-prescription or herbal drugs?	☐	☐	
List:			
Do you have allergies?	☐	☐	☐
If yes, please list: ☐ **Medications** ☐ **Latex/Rubber Products**			
☐ **Other:**			
Have you had any peculiar or adverse reactions to any medications or injections?	☐	☐	☐
If yes, explain:			
Do you have or have you ever had asthma?	☐	☐	☐
Have you ever had any blood pressure problems?	☐	☐	☐
Do you have a prosthetic or artificial joint?	☐	☐	

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Details	Yes	No	Not Sure
Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease), or a heart transplant?	☐	☐	
Do you have any conditions or therapies that could affect your immune system (eg. Leukemia, HIV infection, AIDS, radiotherapy, chemotherapy, etc.)?	☐	☐	
Have you ever had hepatitis, jaundice or liver disease?	☐	☐	☐
Do you have any bleeding problems or disorders?	☐	☐	☐
Have you ever been hospitalized for any illnesses or operations?	☐	☐	
If yes, explain:			
Are there any diseases or medical problems the run in your family (i.e. cancer, diabetes, heart disease, etc.)?	☐	☐	☐
Do you smoke or chew tobacco?	☐	☐	
Are you nervous during dental treatment?	☐	☐	☐
Women only: Are you pregnant or breast feeding?	☐	☐	

Are you currently or have you ever been treated for:

Yes	No	Condition	Details
☐	☐	Alcohol Dependency	
☐	☐	Angina	
☐	☐	Arthritis	
☐	☐	Cancer	
☐	☐	Chest Pain	
☐	☐	Diabetes	
☐	☐	Drug Dependency	
☐	☐	Heart Attack	

Are you currently or have you ever been treated for:			
Yes	**No**	**Condition**	**Details**
☐	☐	Heart Murmur	
☐	☐	Kidney disease	
☐	☐	Lung Disease	
☐	☐	Mitral Valve Prolapse	
☐	☐	Osteoporosis Meds	
☐	☐	Pacemaker	
☐	☐	Rheumatic Fever	
☐	☐	Seizures (epilepsy)	
☐	☐	Shortness of Breath	
☐	☐	Steroid Therapy	
☐	☐	Stomach Ulcers	
☐	☐	Stroke	
☐	☐	Thyroid Disease	
☐	☐	Tuberculosis	
Are there any conditions not listed that you have had at any time?			

Dental History		
Details	**Yes**	**No**
When was your last dental check up?		
When were your last dental x-rays?		
How often do you brush your teeth?		
How often do you floss your teeth?		
Have you been seeing a dentist regularly?	☐	☐

Dental History

Details	Yes	No
Do any of your teeth ache?	☐	☐
Have you been advised to take antibiotics prior to dental appointments?	☐	☐
Do your gums bleed when you brush?	☐	☐
Do you have pain when you chew?	☐	☐
Do you feel that you have bad breath?	☐	☐
Have you ever been in a vehicle accident or experienced any kind of blow to your mouth or jaw?	☐	☐
Have you ever had implant surgery in either of your jaws or TMJ (joints)?	☐	☐
If yes: Surgeon:	Date of Procedure:	
Are you seeing any type of dental specialist?	☐	☐
Are you happy with the appearance of your teeth?	☐	☐

Anything else not mentioned in regard to your dental history? Please explain:

To the best of my knowledge the above information is correct:

Parent/Patient Signature: **Date:**

Dentist Signature: **Date:**