Amy M. Woo, D.D.S.
Kristine E. Balcom, D.D.S.
Patricia Murphy, D.D.S.
Kelly A. Brewer, D.D.S.

Patient Name _____ **Age** _____ **Birthdate** _____
(last) (first)

Sex: ☐ Male ☐ Female ☐ Single ☐ Married ☐ Minor ☐ Other _____

If patient is a minor, parent or guardian's name _____ **Relationship** _____

Name you would like to be addressed as _____ **E-mail address:**_____

Home Address _____ **Home Phone ( )** _____

City _____ **State** _____ **Zip Code** _____

Driver's License # _____ **Social Security #** _____

Employed By _____ **Occupation** _____

Work Phone ( ) _____ **Cellular Phone ( )** _____

Spouse's Name _____ **Social Security #** _____

Spouse's Employer _____ **Occupation** _____

Emergency Contact_____ **Relationship** _____

Complete Address _____ **Phone ( )** _____
Street City Zip Code

Former Dentist _____ **Last Visit** _____

How did you hear about us? Friend/Co-worker/Relative Walk-by/Drive-by Internet Other:_____

Whom may we thank for referring you? _____

PRIMARY DENTAL INSURANCE	SECONDARY DENTAL INSURANCE
Insurance Company	Insurance Company
Billing Address	Billing Address
City State Zip Code	City State Zip Code
Insurance Phone # Group #	Insurance Phone # Group #
Name of insured Relationship to Pt	Name of Insured Relationship to Pt
Social Security# or ID# Birthdate	Social Security# or ID# Birthdate

(continued on reverse)

HEALTH HISTORY

Patient Name: _____ **Birth Date:**_____

E-mail Address: _____ **Phone #** _____

Mailing Address:_____

Any changes with insurance?___:_____

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

Medical Doctor Name _____ **Phone #** _____

If yes, for what? _____ **Date of Last Exam** _____

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

If yes, please explain _____

Are you currently taking or have ever taken in the past:

Bone density meds or Bisphosphonates: Aredia, Zometa, Fosamax, Actonel or other: _____

Blood thinners: Coumadin, Aspirin or other: _____

Weight loss medications/Diet pills: Fen-phen, Meridia, Xenical, Acomplia or other:_____

Please list all medications you are taking and the reason (including over the counter medications, herbal supplements and recreational drugs):

_____

_____

Are you allergic to or have you reacted adversely to any of the following medications? Circle if yes.

PENICILLIN **ERYTHROMYCIN** **SULFA DRUGS** **LATEX**

IBUPROFEN **ASPIRIN** **VICODIN** **CODEINE** **LOCALANESTHETIC**

Are you aware of being allergic to any other medication or substance not listed?

_____

Have you ever had an adverse skin reaction to metals? If yes, list types of metals: _____

Have you ever had any of the following? Circle yes or no:

yes	no	Sexually transmitted Diseases	yes	no	Thyroid Disorders
yes	no	Substance Abuse	yes	no	Systemic Diseases
yes	no	High Blood Pressure	yes	no	Asthma
yes	no	Heart Murmur	yes	no	Sinus Trouble
yes	no	Mitral Valve Prolapse	yes	no	Hepatitis
yes	no	Heart Disease/Family History	yes	no	Tuberculosis
yes	no	Rheumatic Fever	yes	no	Diabetes
yes	no	Metal Pins, Plates or Pacemaker	yes	no	Epilepsy/Seizures
yes	no	HIV/AIDS	yes	no	Bleeding Problems
yes	no	Artificial Joint Placed	yes	no	Tobacco in any form
yes	no	Viral Diseases			

Do you have any disease, condition or problem not listed above? If yes, explain: _____

_____

Have you ever had problems with prior dental treatment? _____

FOR WOMEN ONLY: Are you pregnant? yes no If yes, due date: _____

CONSENT FOR TREATMENT

The above is true and correct to the best of my knowledge. If I ever have a change in my health, I will inform the doctor of that change without fail. I authorize a complete examination, radiographs, cleaning, and other treatment considered necessary, including the use of local anesthesia and medications that may be indicated.

Patient Signature: _____ **Date:**_____ **Dr. Signature:**_____

HEALTH HISTORY UPDATE

I have reviewed the original health history above and certify that it is accurate except for the changes indicated below:

Date	Changes	Patient Signature	Dr. Signature