NOMAD DENTAL PRACTICES

Patient Health History Form

Today's Date _____

Name _____ Date of Birth_____

Home Phone_____ Work Phone _____ Cell_____

Email Address _____

Address _____

City_____ State_____ Zip_____

Person to be billed (if not yourself)_____

Emergency Contact_____ Phone _____

Relationship _____

Your Employer _____

Occupation _____

How were you referred to our office? _____

DENTAL INSURANCE

DO YOU HAVE DENTAL INSURANCE? YES NO

Insured's Name _____ Birth Date _____

Name of Employer _____

Name of Insurance Company _____

Insurance ID # _____ Group Number _____

DO YOU HAVE DOUBLE INSURANCE COVERAGE? YES NO

Insured's Name _____ Birth Date _____

Name of Employer _____

Name of Insurance Company _____

Insurance ID # _____ Group Number _____

Assignment of Benefits
I authorize payment of dental benefits to the named provider for professional services rendered.

Signed _____
(Subscriber)

Release of Information
I authorize the release of any dental information necessary to process this claim.

Signed _____
(Patient or Guardian)

MEDICAL HISTORY

Date of last health care exam by a physician: _____

What was this exam for? _____

Have you been hospitalized in last 5 years? _____

If yes, reason: _____

Are you currently receiving care from a physician? YES NO

If yes, nature of care: _____

Please list contact information (name, phone, fax number) of all your treating physicians:

1. _____
2. _____
3. _____

For the following questions, circle YES or NO. Your answers are for our records only and will remain confidential. We may need to ask additional questions regarding your overall health.

Heart Murmur	NO	YES	Ever taken the drug Fen-Phen	NO	YES
Anemia	NO	YES	Venereal Disease	NO	YES
Diabetes Type I or II Insulin? Latest HbA1c reading:	NO	YES	Psychosis	NO	YES
Epilepsy	NO	YES	Enlarged Lymph Nodes	NO	YES
Hepatitis (any form)	NO	YES	Previous Biopsies	NO	YES
Asthma	NO	YES	Slow healing mouth sores	NO	YES
HIV Positive or AIDS related complex	NO	YES	Recurrent Illnesses	NO	YES
Emphysema or other Respiratory Illnesses, including COPD	NO	YES	Other infections	NO	YES

Heart Disease	NO	YES	Joint Replacement Date of Surgery:	NO	YES
Abnormal Heart Condition	NO	YES	Glaucoma	NO	YES
Do you have a Pacemaker	NO	YES	Abnormal Bleeding from cut	NO	YES
Have you ever had Heart Surgery	NO	YES	Liver Disease (including jaundice)	NO	YES
Previous Bacterial Endocarditis	NO	YES	Latex Sensitivity	NO	YES
Artificial Heart Valve or Heart Valve Surgery	NO	YES	HPV –Human Papilloma Virus	NO	YES
Heart Stent? When Placed?	NO	YES	Pain in Jaw Joints	NO	YES
Stroke	NO	YES	Cancer	NO	YES
Angina	NO	YES	Sleep Apnea	NO	YES
History of Seizures	NO	YES	Gastric Reflux	NO	YES

Are you required to Pre-medicate with antibiotics prior to dental treatment? NO YES

Women: Are you pregnant? NO YES
If no, are you planning a pregnancy in the near future? NO YES
Are you a nursing mother? NO YES
Are you taking birth control pills? NO YES

Abnormal Blood Pressure NO YES
If yes, what is your normal BP reading?

BP Reading taken in our Office (Don't fill in): BP: _____O2%_____Pulse_____ Date:_____

Are you allergic to or have you had a reaction to:
Local anesthetics NO YES
Antibiotics NO YES
If yes, which one(s):
Aspirin NO YES
Codeine, valium, or other sedatives NO YES

Other: _____

Are you a smoker? NO YES
If yes, how much per day? _____

Do you use smokeless tobacco (chew)? NO YES
If yes, how much? _____

Do you consume grapefruit, grapefruit juice, or grapefruit extract? NO YES

Diet:
Food allergies_____

Sugar in your diet: HIGH MODERATE LOW

How many cans of soda do you drink per day? _____

Please list any medications you are currently taking. Please include both prescription and over the counter medications.

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

7. _____ 8. _____

Are you taking any of the following drugs? NO YES

- Tagamet (Cimetidine), Cardizem (diltiazem), Calan, Isoptin (Verapamil), Serzone (nefazodone), Diflucan (fluconazole), Sporonox (itraconazole), Biaxin (clarithromycin) - Circle those you are taking or have recently taken.

Have you ever been treated with Bisphosphonate drugs? NO YES (Fosamax, Aredia, Zometa, Actonel, Boniva)
If so, which ones?
Currently being treated?

Do you take Antacids? NO YES If Yes, how often? _____

Do you take any herbal supplements? NO YES If Yes, which ones? _____

Do you take any diet pills or vitamins? NO YES If Yes, which ones? _____

Miscellaneous Notes:

_____

_____

_____

_____

_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor or hygienist of any change to my health or medications.

_____ _____ _____

Print Name Patient Signature Date

_____ _____

Doctor Signature Date

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medications change, I will inform the dentist at the next appointment without fail.

DATE	ADDITIONS/CHANGES	SIGNATURE	DDS/RDH INITIAL

SMILE EVALUATION

Rate the appearance of your smile on a scale from 1 to 10 (10 being the highest): _____

Please ✔ the statements below that apply to you.

O I wish the color of my teeth were whiter

O I wish my teeth were straighter

O I wish I had a broader smile

O I feel my teeth are too large or too small (circle that which applies)

O I think my gums show too much when I smile

O My smile shows too much space between some of my teeth

O I sometimes hesitate to smile due to the appearance of my smile

O I would like to know what my cosmetic options are to improve the appearance of my smile

O Other: _____

OCCLUSAL/TMD QUESTIONAIRE

Please mark a ✔ next to any symptom you currently are experiencing or have experienced in the past.

O Headaches

O TMJ Joint Pain

O TMJ Joint Noises (Clicking or Popping)

O Limited opening of your mouth

O Clenching or Grinding of your teeth

O Facial Pain

O Snoring at night

Notes:

_____
_____
_____
_____
_____
_____

PATIENT INTERVIEW

DO NOT FILL OUT – TO BE FILLED OUT BY DOCTOR IVERSON

What prompted you to seek dental treatment at this time?

_____
_____

How long since your last dental exam? _____

Are you experiencing any discomfort or problems with your mouth?

_____
_____
_____

Do your gums ever bleed when brushing or flossing? _____

How often do you brush? _____ Floss? _____

Have you had your wisdom teeth removed? _____
Have you had other adult teeth removed? _____
If so, have they been replaced? _____

Dental History

_____
_____

Rate your own overall oral health as: Good Fair Poor Comments: _____

Are you apprehensive or fearful about receiving dental treatment?

_____
_____
_____

Do you feel you'd benefit from Sedation Dentistry? YES NO

Other:

_____
_____
_____
_____
_____
_____
_____
_____