Carolina Smiles
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Feb 17, 2021

Health History

Please fill in the following information. Your answers are for our records only and will be kept strictly confidential subject to applicable laws. Please note that you will be asked some questions concerning your health. This information is vital to allow us to provide you the best care possible.

Patient Demographics

First name - Patient	Middle name	Nickname/Preferred name	Last name - Patient
x	-	-	x

Patient birth date	Gender	Marital status	Social Security number
-	Male	Not specified	-

Contact Information

Home #	Work #	Mobile #
-	-	-

Email address	Preferred contact method	Best time to call
-	Cell phone	No selection

Emergency Information

Emergency contact	Emergency #
-	-

Electronic communication

Our office sends out Appointment Reminders: Please list your preference below

- ☐ I approved to be contacted by Text message
- ☐ I approve to be contacted by E-Mail
- ☐ I approved to be contacted via Text and E-mail
- ☐ I declined to be contacted by Text or E-Mail. I prefer Phone Calls

Physical Address and Mailing if Different

Patient mailing address	Patient billing address	
Marble, NC, US	Marble, NC, US	☐ Were you referred to this office?
-	-	-

Family doctor
-

Family doctor #
-

☐ Has the main contact for the family, (usually a parent or guardian) changed since your last visit?
-

☐ Has the main person responsible for payments for the family, (usually a parent or guardian) changed since your last visit?
-

Occupation
-

☐ Has your insurance information changed since your last visit?
-

☐ Acknowledged practice privacy practices

☐ Acknowledged HIPAA regulations

Employer
-

Previous provider
-

Previous provider phone
-

☐ Dental Insurance Information
-

☐ Insured's Name
-

☐ Insured's S.S. #
-

☐ Insured's Date of Birth
-

Dental Information

☐ Do your gums bleed when you brush or floss?

☐ Do you have any other Disease or Condition not listed that your Dentist should know about before proceeding with treatment?
-

☐ Are you currently experiencing dental pain or discomfort?

☐ Are you required to Antibotic Pre-Medication?
-

☐ Have you had any problems associated with previous dental treatment?

☐ Have you ever been told that you have Gum Disease or any other dental condition that the Doctor should know about?
-

☐ Do you have any clicking, popping or discomfort in your jaw?

Medical Information

☐ Do you use a C-Pap or Bi-Pap
-

☐ Do you take any Medications? if Yes, Please List
-

☐ Are you hard to numb
-

Allergies

☐ Acetaminophen/Tylenol®

☐ Acrylic

☐ Amoxicillin

☐ Aspirin

- [ ] Clindamycin
- [ ] Codeine
- [ ] Erythromycin
- [ ] Food
- [ ] Hay fever/seasonal
- [ ] Hydrocodone
- [ ] Ibuprofen/Motrin®/Advil®
- [ ] Iodine
- [ ] Latex
- [ ] Local anesthetic
- [ ] Metals
- [ ] Penicillin
- [ ] Sulfa
- [ ] Other

-

Reactions

-

Conditions

- [ ] Abnormal/excessive bleeding
- [ ] AIDS or HIV infection
- [ ] Alzheimer's/dementia
- [ ] Anemia
- [ ] Angina
- [ ] Anxiety
- [ ] Arthritis
- [ ] Artificial heart Valve/Heart Stents
- [ ] Asthma
- [ ] Autoimmune disease
- [ ] Back problems
- [ ] Blood disease
- [ ] Blood Thinners
- [ ] Breathing problems/ respiratory disease
- [ ] Cancer/chemotherapy/ radiation treatment
- [ ] Cardiovascular disease
- [ ] Chest pain upon exertion
- [ ] Chronic pain
- [ ] Congestive heart failure
- [ ] Damaged heart valves
- [ ] Diabetes
- [ ] Dizzyness
- [ ] Do you consume Alcohol?
- [ ] Epi Caution/No Epi
- [ ] Epilepsy
- [ ] Fainting spells or seizures
- [ ] Frequent Chest Pains
- [ ] Frequent headaches
- [ ] Gastrointestinal disease
- [ ] Glaucoma
- [ ] Heart attack
- [ ] Heart rhythm disorder
- [ ] Heart Surgery
- [ ] Hepatitis, jaundice or liver disease
- [ ] High blood pressure
- [ ] Hives / Skin Rashes
- [ ] Hypoglycemic
- [ ] Joint Replacement
- [ ] Kidney Disease
- [ ] Low blood pressure
- [ ] Medications
- [ ] Medications for Bones/ IV Infusions for Bones
- [ ] Multiple Sclerosis
- [ ] Neurological disorders
- [ ] Osteoporosis/Paget's disease
- [ ] Other congenital heart defects
- [ ] Pacemaker
- [ ] Persistent swollen glands in neck
- [ ] Physical Challenges
- [ ] Pregnant
- [ ] Psychiatric care
- [ ] Recurrent Infections
- [ ] Rheumatic fever
- [ ] Rheumatic heart disease
- [ ] Rheumatoid arthritis
- [ ] Sinus trouble

- [ ] Stroke
- [ ] Thyroid problems
- [ ] Tobacco User?
- [ ] Tumors or growths
- [ ] Ulcers
- [ ] Other

-

Details

-

Preferred pharmacy

-

Pharmacy #

-

Date of last physical exam

-

- [ ] Have you ever reacted adversely to any medications or injections?
- [ ] Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?

-

- [ ] Has there been any change to your general health within the past year?

-

- [ ] Have you had a serious illness, operation or been hospitalized in the past 5 years?

-

- [ ] Do you have sleep apnea?
- [ ] Are you taking birth control or hormone replacement?
- [ ] Are you nursing?

Please list any surgical procedures you have undergone and when they occurred.

-

- [ ] Have you ever taken FosaMax®, Boniva®, Actonel®, Prolia or other medications containing bisphosphonates?
- [ ] Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

-

Physician's phone number

-

Please read the above, and understand that the information provided in this form is accurate. A truthful health history will help ensure the best possible dental treatment. The information provided here will be used by the doctor and patient to inform any further discussion of the patient's health prior to or during an appointment. By signing below you also acknowledge that you will not hold the dentist, the dental practice or any other member of the practice staff responsible for any action or lack of action because of errors or omissions that may have been made during the completion of this form.

Form History

✓ Completed	Feb 17, 2021 10:22:29 EST	The form has been completed