HEALTH HISTORY FOR_____**Date**_____

DENTAL HISTORY

Dentist's Name_____ Referred By_____

Date of last dental visit?_____

What service was performed?_____

Reason for this visit at Dr. Elassal's office?_____

Are you having pain at this time?____Y____N

Have you ever had:		
Orthodontic treatment (braces)	____Yes	____No
Oral surgery	____Yes	____No
Gum treatment	____Yes	____No
Your teeth ground or the bite adjusted	____Yes	____No
Worn a bite plane or other appliance	____Yes	____No
Have you noticed any loosening of your teeth?	____Yes	____No
Does food tend to become caught between your teeth?	____Yes	____No
Do your gums often bleed when you brush your teeth?	____Yes	____No
Do you have any sores or lumps in or near your mouth?	____Yes	____No
Problems of the jaw. Have you experienced:		
Clicking of the jaw	____Yes	____No
Pain (joint, ear, side of face)	____Yes	____No
Difficulty in opening or closing	____Yes	____No
Difficulty in chewing	____Yes	____No
Have you had any head, neck or jaw injuries?	____Yes	____No
Clench or grind your teeth while awake or asleep?	____Yes	____No
Bite your lips or cheeks regularly?	____Yes	____No
Are you satisfied with the appearance of your teeth?	____Yes	____No
Is there anything about having dental treatment that bothers you?	____Yes	____No

If so, please explain._____

MEDICAL HISTORY

Physician's Name_____

Phone #_____Date of last visit_____

Are you currently under the care of a physician?	____Yes	____No
If yes, please explain._____		
Has there been any change in your general health within the past year?	____Yes	____No
Have you been hospitalized for any surgical operation or serious illness within the past year?	____Yes	____No
Have you had surgery or x-ray treatment for a tumor, growth or other condition of your mouth or lips?	____Yes	____No
Does anyone in your family have any disability, birth defects or growth related problems?	____Yes	____No

PLEASE COMPLETE THE OTHER SIDE

Have you ever had any of the following diseases or medical problems?

Y	N	Allergies	Y	N	Hemophilia/Abnormal Bleeding
Y	N	Anemia	Y	N	Hepatitis
Y	N	Arthritis	Y	N	High/Low Blood Pressure
Y	N	Artificial Bone/Joints	Y	N	HIV+/AIDS
Y	N	Asthma	Y	N	Hives or Skin Rash
Y	N	Bladder	Y	N	Kidney Trouble Pressure
Y	N	Cancer/Chemotherapy	Y	N	Leukemia
Y	N	Cerebral Palsy	Y	N	Liver Disease or Jaundice
Y	N	Chemical Dependency	Y	N	Lung/Breathing Problems
Y	N	Congenital Heart Defect	Y	N	Mitral Valve Prolapse
Y	N	Diabetes	Y	N	Rheumatic Fever
Y	N	Epilepsy	Y	N	Severe/Frequent Headaches
Y	N	Fainting/ Seizures	Y	N	Shingles
Y	N	Fever Blisters	Y	N	Sinus Problems
Y	N	Glaucoma	Y	N	Thyroid
Y	N	Heart Attack/ Stroke	Y	N	Tuberculosis
Y	N	Heart Murmur	Y	N	Ulcers/Colitis
Y	N	Heart Surgery/Pacemaker	Y	N	Venereal Disease
Y	N	Fever of Unknown Origin	Y	N	Night Sweats
Y	N	Unexplained Weight Loss	Y	N	Bloody Cough
Y	N	Prolonged Cough (3-4 weeks)			

Women:

Are you pregnant or think you might be pregnant? ____Yes ____No
Are you nursing? ____Yes ____No
Are you using oral contraceptives? ____Yes ____No

Please list all medications that you are currently taking: _____
_____
Please list all drugs that you are allergic to:_____
_____
Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information I should be aware of:_____
_____

May we request a release of your medical records?____Y____N

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment

_____
Signature Date

In order to file your insurance, the following section must be completed by an authorized party.

I hereby authorize release of any information relating to this claim.

Signature_____ Date_____

I hereby authorize payment of insurance benefits directly to the dentist.

Signature_____ Date_____