LAKE BOONE DENTISTRY
RALEIGH

PATIENT HEALTH HISTORY FORM

Date_____

Mr. Mrs. Dr. Other_____ Name_____ Preferred Name_____

Sex: ___F ___ M Marital Status: _____Married _____Single_____Divorced _____Widowed Birthdate_____

Soc. Sec #_____ Person Responsible for Account/Insurance Subscriber_____

Employer/Occupation_____If Child, Name of Parent/Guardian_____

Address_____
Street City State Zip Code

Telephone: Home_____ Mobile_____Work_____Other_____

Email Address _____ Referred By _____

Emergency Contact_____
Name Relationship Phone Number

Do You Have Dental Insurance _____Yes _____No (Please Provide Dental Card and Information At The Front Desk)

Do you currently have or have you previously had any of the following conditions? Please check any that apply to you.

- ☐ Heart Trouble
- ☐ Heart Murmur
- ☐ Angina/Chest Pain
- ☐ Heart Attack
- ☐ Congestive Heart Failure
- ☐ Mitral Valve Prolapse
- ☐ Rheumatic Fever
- ☐ Heart Surgery
- ☐ High/Low Blood Pressure
- ☐ Blood Disease/Bleeding Disorder
- ☐ Anemia
- ☐ Hemophilia
- ☐ Leukemia
- ☐ Drug/Alcohol Addiction
- ☐ Shortness of Breath
- ☐ Hay Fever
- ☐ Emphysema/Lung Disease
- ☐ Tuberculosis
- ☐ Cancer
- ☐ Radiation Treatment
- ☐ Chemotherapy
- ☐ Stomach/Intestinal Disease
- ☐ Diabetes
- ☐ Liver Disease
- ☐ Hepatitis
- ☐ Kidney Problems
- ☐ Arthritis/Gout
- ☐ Joint Replacement
- ☐ AIDS/HIV
- ☐ Thyroid Conditions
- ☐ Stroke (CVA)
- ☐ Epilepsy/Seizures
- ☐ Fainting/Dizziness
- ☐ Glaucoma
- ☐ Nervousness
- ☐ Allergies/Hives/Rash
- ☐ Pregnanacy
- ☐ Other Health Issues

Other Health Problems Not Listed Above _____

Do You Need Pre-Medication for Dental Treatments? _____

Do You Have Any Allergies to Medications?

- ☐ Penicillin
- ☐ Antibiotics
- ☐ Sulfa Drugs
- ☐ Aspirin
- ☐ Codine/Narcotics
- ☐ Local Anesthetics
- ☐ Other (List)
- ☐ _____
- ☐ _____

List Medications Currently Taking_____

_____

_____

Are You Under A Physician Care Now? Why? _____

Physician Name and Phone Number _____

Have You Been Hospitalized or had a Major Operation within the last 5 Years? If so please elaborate_____

_____

_____

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DENTAL HISTORY

Name and Address of Your Last Dentist_____

_____

When Was Your Last Cleaning/Dental Appointment?_____

What is Your Main Reason for this Dental Visit?_____

Are You Currently Having Pain or any Other Problems?_____

Do You Currently Use or have a History of Using Tobacco Products? (Smoking, Chewing, etc.) _____Yes _____No

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All accounts are to be paid in full within 90 days of service. A charge of 1.5% interest will be applied to balances over 90 days old. Failure to meet payment terms may result in a credit blemish on your permanent credit report. Parents or legal guardians of a minor are responsible for costs incurred by that minor. In the event a legal suit or if outside collections are necessary to enforce payment of the account, the patient agrees to pay for all collection fees, attorney's fees, and court costs as may be deemed reasonable.

I have read and understand the above policies and to the best of my knowledge, all of the preceding answers are correct. If a patient is a minor, as parent or legal guardian, I give consent for routine dental treatment including local anesthesia.

Sign _____ **Date**_____

MEDICAL UPDATES

Date	Changes	Patient's Signature	Reviewed By

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