Hamilton Dental Group

HEALTH HISTORY

For your welfare and our efficiency of diagnosis and treatment, please fill in the following confidential form completely.

Name of Medical Doctor _____

Doctor's Address _____

	Circle	
1. Have you been a patient in a hospital during the past 5 years?	Yes	No
2. Have you ever been under the care of a medical doctor during the past 5 years?	Yes	No
3. Have you ever taken any kind of medicine or drugs during the past year?	Yes	No
4. Are you allergic to penicillin or other antibiotic, codeine, aspirin, novocaine or other drugs or medicine?	Yes	No
5. Have you ever had any excessive bleeding requiring special treatment?	Yes	No
6. Tested HIV positive?	Yes	No

Circle any of the following which you have had:

Heart trouble	Jaundice	Arthritis	Nervous disorder
Congenital heart lesions	Asthma	Stroke	Venereal disease
Heart murmur	Cough	Epilepsy	Fainting
High or low blood pressure	Diabetes	Psychiatric treatment	Dizziness
Anemia	Tuberculosis	Sinus trouble	Kidney problems
Rheumatic fever	Hepatitis	Heart attack	Liver problems

7. Have you had any other serious illnesses?	Yes	No
8. (Women) Are you pregnant now?	Yes	No

9. Approximate date of last dental visit? _____
10. Approximate date when teeth were last cleaned? _____
11. Approximate date of last full mouth X-Ray? _____
12. If you have dentures, how long have you been wearing your present dentures? _____
13. Approximate date of last repair or reline of dentures? _____
14. Do you feel that saving your teeth is a waste of time? Yes No

PATIENT INFORMATION

TODAY'S DATE _____

PATIENT NAME _____

SINGLE ? MARRIED ? SEPARATED ? DIVORCED ? WIDOWED ?
HOME PHONE _____ DATE OF BIRTH _____
ADDRESS: STREET _____
CITY _____ STATE _____ ZIP CODE _____

AFTER INSURANCE WHO WILL PAY THIS ACCOUNT _____
HIS(HER) SOCIAL SECURITY NUMBER _____ RELATIONSHIP _____

EMPLOYED BY _____
BUSINESS ADDRESS _____
PRESENT POSITION _____ HOW LONG HELD _____
WORK PHONE _____
SPOUSE'S NAME _____
SPOUSE EMPLOYED BY _____
BUSINESS ADDRESS _____
PRESENT POSITION _____ HOW LONG HELD _____
WORK PHONE _____
NAME OF DENTAL INSURANCE COMPANY _____
INSURED SS# _____ INSURED DOB _____

CHILD ONLY

PARENT OR GUARDIAN'S NAME _____

NOTE: IF PERSON RESPONSIBLE FOR PAYING THIS BILL IS OTHER THAN CUSTODIAL PARENT OR GUARDIAN, PLEASE CHECK THIS BOX ?

I UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR TOTAL PAYMENT OF PROCEDURES PERFORMED IN THIS OFFICE INCLUDING ANY AMOUNTS WHICH ARE NOT COVERED BY ANY DENTAL INSURANCE THAT I MAY HAVE.

X SIGNATURE _____

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