HIGHLINE
FAMILY DENTISTRY
COSMETIC • RESTORATIVE • IMPLANTS

PATIENT HEALTH HISTORY FORM

2 West Dry Creek Circle, Suite 125 Littleton, CO 80120 (303) 794-6800

Patient Name: _____ **Date of Birth:** _____ **Date:** _____

Email: _____ **If minor, Parent/Guardian Name:** _____

Home Phone: _____ **Cell :** _____ **Work Phone:** _____

Medical

	Yes	No	DK
Has there been a major change to your health within the past year?	☐	☐	☐
If yes, please explain: _____			
Are you under the care of a physician or are you receiving ongoing medical care?	☐	☐	☐
Name of your physician: _____			
Physician's phone number: _____			
Date of your last medical visit: _____			
Are you pregnant?	☐	☐	☐
If yes, due date: _____			
Do you breast feed?	☐	☐	☐
Do you have any artificial joints, heart valves, implants, or prosthesis?	☐	☐	☐
Have you ever been told you need to be pre-medicated prior to dental treatment?	☐	☐	☐
Have you had surgery, x-ray treatment, or chemotherapy for a tumor, growth, or other condition?	☐	☐	☐
If yes, please explain: _____			

Dental

	Yes	No	DK
Are you having any dental discomfort at this time?	☐	☐	☐
If yes, please explain: _____			
Have you ever had serious trouble with previous dental work?	☐	☐	☐
If yes, please explain: _____			
Does dental work make you nervous?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Have you ever had any abnormal bleeding associated with previous extractions, surgery, or trauma?	☐	☐	☐
If yes, please explain: _____			
Date of your last dental visit: _____			
How often do you brush your teeth? _____			
How often do you floss your teeth? _____			

Other

Please check the answer that is right for you, "Yes", "No", "DK" (Don't know)

	Yes	No	DK		
Do you use tobacco?	☐	☐	☐	What? _____	How much? _____
Do you use alcohol?	☐	☐	☐	What? _____	How much? _____
Do you have any CURRENT/PAST history of substance abuse?	☐	☐	☐	If yes, please explain: _____	

Medications

Are you taking any prescription or over the counter medications? Yes ☐ No ☐ DK ☐

Please list all medications you are taking (Please include prescription and non-prescription medications):

	Medication:	Dosage:	How Often taken:	Reason for medication:
1.				
2.				
3.				

Allergies

Are you allergic to anything? Yes ☐ No ☐ DK ☐

Please list all allergies including reaction:

	Allergy to:	Reaction:
1.		
2.		

Patient Insurance Information

Dental Insurance Company: _____ **Employer:** _____

Employee Name: _____ **Employee ID:** _____ **DOB:** _____

HIGHLINE
FAMILY DENTISTRY

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Medical Information:

Heart and Circulatory Problems

	Yes	No	DK
Heart Attack	☐	☐	☐
If yes, when: _____			
High Blood Pressure	☐	☐	☐
Chest Pain (Angina)	☐	☐	☐
Heart Murmurs	☐	☐	☐
Artificial Valve	☐	☐	☐
Other Heart Problems	☐	☐	☐

Comments: _____

	Yes	No	DK
Diabetes - Type 1	☐	☐	☐
Diabetes - Type 2	☐	☐	☐
Thyroid Problems	☐	☐	☐
Other Gland Problems	☐	☐	☐

Comments: _____

Breathing/Lung Problems

	Yes	No	DK
Hay Fever	☐	☐	☐
Shortness of Breath	☐	☐	☐
Persistent Cough	☐	☐	☐
Positive Test/Treatment for Tuberculosis	☐	☐	☐
Seasonal Allergies	☐	☐	☐
Asthma	☐	☐	☐
Emphysema	☐	☐	☐
Do you snore?	☐	☐	☐

Comments: _____

Skin Problems

	Yes	No	DK
Rashes	☐	☐	☐
Mole Changes	☐	☐	☐

Comments: _____

Stomach Problems

	Yes	No	DK
Stomach Pain	☐	☐	☐
Heartburn	☐	☐	☐
History of Ulcers	☐	☐	☐
Colitis	☐	☐	☐

Comments: _____

Mental Health Problems

	Yes	No	DK
Depression	☐	☐	☐
Anxiety	☐	☐	☐
History of Psychiatric Medications	☐	☐	☐

Comments: _____

Other

	Yes	No	DK
Immune System Disorders	☐	☐	☐
Hepatitis A, B, or C	☐	☐	☐
AIDS/HIV	☐	☐	☐
Kidney or Bladder Problems	☐	☐	☐
Frequent Urinary Tract Infections	☐	☐	☐

Comments: _____

Neurological Problems

	Yes	No	DK
Epilepsy/Seizures	☐	☐	☐
Chronic Headaches	☐	☐	☐
History of Head Injury	☐	☐	☐
Numbness of Arms, Legs, Hands or Feet	☐	☐	☐
History of Stroke	☐	☐	☐
If yes, when: _____			
Fainting Spells	☐	☐	☐

Comments: _____

Blood Problems

	Yes	No	DK
Bleeding Problems	☐	☐	☐
Anemia	☐	☐	☐
Hemophilia	☐	☐	☐
Are you taking blood thinners?	☐	☐	☐

If yes, recent INR level: _____

Comments: _____

Muscle and Bone Problems

	Yes	No	DK
Joint/Back Pain	☐	☐	☐
History of Broken Bones	☐	☐	☐
Joint Swelling	☐	☐	☐
Arthritis	☐	☐	☐
Osteoporosis	☐	☐	☐

Comments: _____

Additional

Do you have any other disease, condition or problem not listed? ☐ ☐ ☐

If yes, please explain _____

Comments: _____

The undersigned hereby authorizes Doctor to take radiographies, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patients dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with (Name of Patient) _____ and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodys a certain risk. I grant the right to the Dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due payable at the time services are rendered. I further understand that a 1.5% finance charge (18% annually) will be added to my balance over 60 days. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be to effect collection of the note. The information on this page and the dental/medical histories are correct to the best of my knowledge.

Signature of Patient or Guardian _____ **Date** _____