



PATIENT HEALTH HISTORY FORM

HIGHLINE
— FAMILY DENTISTRY —
COSMETIC • RESTORATIVE • IMPLANTS

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

Patient Name: _____ Date of Birth: _____ Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Email: _____ If minor, Parent/Guardian Name: _____
Home Phone: _____ Cell : _____ Work Phone: _____

Medical

Has there been a major change to your health within the past year? Yes No DK

If yes, please explain: _____

Are you under the care of a physician or are you receiving ongoing medical care? Yes No DK

Name of your physician: _____
 Physician's phone number: _____
 Date of your last medical visit: _____

Are you pregnant? Yes No DK

If yes, due date: _____

Do you breast feed? Yes No DK

Do you have any artificial joints, heart valves, implants, or prosthesis? Yes No DK

Have you ever been told you need to be pre-medicated prior to dental treatment? Yes No DK

Have you had surgery, x-ray treatment, or chemotherapy for a tumor, growth, or other condition? Yes No DK

If yes, please explain: _____

Dental

Are you having any dental discomfort at this time? Yes No DK

If yes, please explain: _____

Have you ever had serious trouble with previous dental work? Yes No DK

If yes, please explain: _____

Does dental work make you nervous? Yes No DK

Do you brux or grind your teeth? Yes No DK

Have you ever had any abnormal bleeding associated with previous extractions, surgery, or trauma? Yes No DK

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)

Do you use tobacco? Yes No DK What? _____ How much? _____

Do you use alcohol? Yes No DK What? _____ How much? _____

Do you have any CURRENT/PAST history of substance abuse? Yes No DK If yes, please explain: _____

Medications Yes No DK

Are you taking any prescription or over the counter medications?

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 Yes No DK

Are you allergic to anything?

Please list all allergies including reaction:

Allergy to:	Reaction:
1. _____	_____
2. _____	_____

Patient Insurance Information

Dental Insurance Company: _____ Employer: _____
 Employee Name: _____ Employee ID: _____ DOB: _____



PATIENT HEALTH HISTORY FORM

Medical Information:

Heart and Circulatory Problems

Heart Attack, High Blood Pressure, Chest Pain (Angina), Heart Murmurs, Artificial Valve, Other Heart Problems. Includes Yes/No/DK checkboxes and a comments line.

Diabetes - Type 1, Diabetes - Type 2, Thyroid Problems, Other Gland Problems. Includes Yes/No/DK checkboxes and a comments line.

Breathing/Lung Problems

Hay Fever, Shortness of Breath, Persistent Cough, Positive Test/Treatment for Tuberculosis, Seasonal Allergies, Asthma, Emphysema, Do you snore?. Includes Yes/No/DK checkboxes and a comments line.

Skin Problems

Rashes, Mole Changes. Includes Yes/No/DK checkboxes and a comments line.

Stomach Problems

Stomach Pain, Heartburn, History of Ulcers, Colitis. Includes Yes/No/DK checkboxes and a comments line.

Mental Health Problems

Depression, Anxiety, History of Psychiatric Medications. Includes Yes/No/DK checkboxes and a comments line.

Other

Immune System Disorders, Hepatitis A, B, or C, AIDS/HIV, Kidney or Bladder Problems, Frequent Urinary Tract Infections. Includes Yes/No/DK checkboxes and a comments line.

Neurological Problems

Epilepsy/Seizures, Chronic Headaches, History of Head Injury, Numbness of Arms, Legs, Hands or Feet, History of Stroke, Fainting Spells. Includes Yes/No/DK checkboxes and a comments line.

Blood Problems

Bleeding Problems, Anemia, Hemophilia, Are you taking blood thinners?, If yes, recent INR level: Includes Yes/No/DK checkboxes and a comments line.

Muscle and Bone Problems

Joint/Back Pain, History of Broken Bones, Joint Swelling, Arthritis, Osteoporosis. Includes Yes/No/DK checkboxes and a comments line.

Additional

Do you have any other disease, condition or problem not listed? Includes Yes/No/DK checkboxes, a space for explanation, and multiple lines for comments.

The undersigned hereby authorizes Highline Family Dentistry, Dr. Becker to take radiographies, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Becker to make a thorough diagnosis of the patients dental needs. I also authorize Dr. Becker 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 Dr. Becker choose and employ such assistance as she deems fit. I also understand the use of anesthetic agents embodies a certain risk. I grant the right to Highline Family Dentistry 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 _____