Patient Health History

Patient Name: _____ Date of Birth: _____SSN:_____

Address:_____City:_____State:_____ Zip Code: _____

Home Phone:_____ Cell:_____ Work:_____

Sex: ☐ Male ☐Female ☐Minor ☐Single ☐Married ☐Partner ☐Divorced ☐Widowed

Email Address: _____Referred by:_____

Emergency Contact: _____Phone: _____

Medical History

1. Date of last physical exam: _____ Physician's Name: _____

Physician's Phone: _____

2. Have you ever been hospitalized (if yes, explain below)? ☐Yes ☐ No

_____

3. Have you been under the care of a medical doctor during the past two years? ☐Yes ☐ No

If yes, what for? _____

4. Have you had any joints replaced? ☐Yes ☐No (Hip, Knee, Shoulder, etc.) When?

_____ 5. Have you ever been told you need antibiotics before dental treatment? ☐Yes

☐No Why? _____

6. Do you take any blood thinners? ☐Yes ☐No (Xarelto, Warfarin, Coumadin, Eliquis, etc.)

7. Women: Are you pregnant/trying to get pregnant/breast feeding? ☐Yes ☐No

8. Are you allergic to or have you had an allergic reaction to any of the following (please circle if yes):

Local Anesthetic Penicillin Codeine Sulfa Other Antibiotic: _____

Latex Acrylic Metals Other:_____

9. Are you taking or have you ever taken any of the following medications (please circle if yes):

Fosamax Actonel Boniva For how long? _____

Aredia Reclast Zometa When did you stop? _____

10. Please list all medications you are taking:

_____

_____

Have you ever had any of the following?

Abnormal Bleeding ☐Yes ☐ No

Alcohol/ Drug Abuse ☐Yes ☐ No

Anemia ☐Yes ☐ No

Arthritis ☐Yes ☐ No

Radiation Treatment ☐Yes ☐ No

Rheumatic Fever ☐Yes ☐ No

Fainting Spells ☐Yes ☐ No

Frequent Headaches ☐Yes ☐ No

Pacemaker ☐Yes ☐ No

Hay Fever ☐Yes ☐ No

Artificial Heart Valve ☐Yes ☐ No

Asthma ☐Yes ☐ No

Low Blood Pressure ☐Yes ☐ No

Mitral Valve Prolapse ☐Yes ☐ No

HPV ☐Yes ☐ No

Heart Attack ☐Yes ☐ No When? _____

Heart Murmur ☐Yes ☐ No

Heart Surgery ☐Yes ☐ No

Blood Transfusion ☐Yes ☐ No | Hemophilia ☐Yes ☐ No | Cancer/ Chemotherapy ☐Yes ☐ No

Hepatitis (A, B, C/D) ☐Yes ☐ No | Herpes/ Fever Blisters ☐Yes ☐ No | Sinus Issues ☐Yes ☐ No

Congenital Heart Defect ☐Yes ☐ No | High Blood Pressure ☐Yes ☐ No | Stroke ☐Yes ☐ No When?_____

Diabetes ☐Yes ☐ No | HIV+/ AIDS ☐Yes ☐ No | Thyroid Problems ☐Yes ☐ No

Difficulty Breathing ☐Yes ☐ No | Tuberculosis (TB) ☐Yes ☐ No | Emphysema ☐Yes ☐ No

Kidney Disease ☐Yes ☐ No | Epilepsy/ Seizures ☐Yes ☐ No | Liver Disease ☐Yes ☐ No

Dental History

1. Date of last dental exam:_____ Date of last dental x-rays: _____
2. Previous dentist's name/location:_____
3. Are you having tooth or gum pain at this time? ☐Yes ☐ No
4. Do your gums bleed when brushing / flossing? ☐Yes ☐No
5. Do you smoke or use tobacco in any other form? ☐Yes ☐ No
6. Have you ever had a bad experience in a dental office? ☐Yes ☐No
7. Are you interested in teeth whitening trays? ☐Yes ☐No
8. Are you interested in Invisalign? ☐Yes ☐ No
9. Would you be interested in a Snore Guard? ☐ Yes ☐No
10. Would you be interested in discussing ways to improve your smile? ☐ Yes ☐ No

If yes, please explain:

_____

Do you have any of the following dental concerns?

Clicking in jaw joint ☐Yes ☐No | Sensitivity to: ☐Hot ☐Cold ☐Sweets ☐Biting

Pain in or around your ears ☐Yes ☐No | ☐Swelling ☐ Bleeding Gums

Difficulty opening or closing ☐Yes ☐No | ☐Bad Taste ☐Bad Breath

Difficulty chewing ☐Yes ☐No | ☐Food Catching ☐Tooth Pain

History of trauma to jaw or face ☐Yes ☐No | ☐Clenching ☐Grinding

Diagnosis of TMJ/TMD ☐Yes ☐No | Other:_____

Assignment and Release:

I hereby authorize payment directly to Shannon F. Harringer, DDS for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. Office policy limits accounts to 30 days without late payment charge of 1 ½% per month. I authorize the use of this signature on all insurance submissions.

Cancellations and Missed Appointments:

We require 24 hours notice of a cancellation. Patients that do not provide 24 hours notice of a cancellation or who do not present for a scheduled appointment will be charged a $50.00 fee.

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. If there is any change in my medical status, I will inform the dentist.

Signature: _____ Date_____

Doctor's Signature_____

Doctor's Notes:

Shannon F. Harringer, DDS Kent W. Wilson, DDS

1941 Huntington Dr., Suite B, South Pasadena, CA 91030 (626)441-1167