

HEALTH HISTORY

Patient Name: _____ Preferred Name: _____

Patient Birth Date: _____

I. CIRCLE APPROPRIATE ANSWER (leave Blank if you do not understand question):

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years?
If YES, why? _____
4. Yes No Are you being treated by a physician now? For what? _____
Date of last medical exam? _____ Date of last Dental exam _____
5. Yes No Have you had problems with prior dental treatment?
6. Yes No Are you in pain now?
7. Yes No Do you require antibiotic pre-medication before dental work?

II. HAVE YOU EXPERIENCED:

- | | | | |
|-------------|--|------------|------------------------|
| 8. Yes No | Chest pain (angina)? | 18. Yes No | Dizziness? |
| 9. Yes No | Swollen ankles? | 19. Yes No | ringing in ears? |
| 10. Yes No | Shortness of breath? | 20. Yes No | Headaches? |
| 11. Yes No | Recent weight loss, fever, night sweats? | 21. Yes No | Fainting spells? |
| 12. Yes No | Persistent cough, coughing up blood? | 22. Yes No | Blurred vision? |
| 13. Yes No | Bleeding problems, bruising easily? | 23. Yes No | Seizures? |
| 14. Yes No | Sinus problems? | 24. Yes No | Excessive thirst? |
| 15. Yes No | Difficulty swallowing? | 25. Yes No | Frequent urination? |
| 16. Yes No | Diarrhea, constipation, blood in stools? | 26. Yes No | Dry mouth? |
| 17. Yes No | Frequent vomiting, nausea? | 27. Yes No | Jaundice? |
| 17a. Yes No | Difficulty urinating, blood in urine? | 28. Yes No | Joint pain, stiffness? |

III. DO YOU HAVE OR HAVE YOU HAD:

- | | | | |
|------------|---|------------|---------------------------|
| 29. Yes No | Heart disease? | 40. Yes No | AIDS |
| 30. Yes No | Heart attack, heart defects? | 41. Yes No | Tumors, cancer? |
| 31. Yes No | Heart murmurs? | 42. Yes No | Arthritis, rheumatism? |
| 32. Yes No | Rheumatic fever? | 43. Yes No | Eye diseases? |
| 33. Yes No | Stroke, hardening of arteries? | 44. Yes No | Skin diseases? |
| 34. Yes No | High blood pressure? | 45. Yes No | Anemia? |
| 35. Yes No | Asthma, TB, emphysema, other lung diseases? | 46. Yes No | VD? |
| 36. Yes No | Hepatitis, other liver disease? | 47. Yes No | Herpes? |
| 37. Yes No | Stomach problems, ulcers? | 48. Yes No | Kidney, bladder disease? |
| 38. Yes No | Allergies to: drugs, foods, medications, latex? | 49. Yes No | Thyroid, adrenal disease? |
| 39. Yes No | Family history of diabetes, heart problems, tumors? | 50. Yes No | Diabetes? |

IV. DO YOU HAVE OR HAVE YOU HAD:

- | | | | |
|------------|-------------------------|------------|---------------------|
| 51. Yes No | Psychiatric care? | 56. Yes No | Hospitalization? |
| 52. Yes No | Radiation treatments? | 57. Yes No | Blood transfusions? |
| 53. Yes No | Chemotherapy? | 58. Yes No | Surgeries? |
| 54. Yes No | Prosthetic heart valve? | 59. Yes No | Pacemaker? |
| 55. Yes No | Artificial joint? | 60. Yes No | Contact lenses? |

V. ARE YOU TAKING:

- | | | | |
|------------|---|------------|----------------------|
| 61. Yes No | Recreational drugs? | 63. Yes No | Tobacco in any form? |
| 62. Yes No | Drugs, medications, over-the-counter medicine
(including Aspirin), natural remedies? | 64. Yes No | Alcohol? |

Please

list: _____

Please list ALL allergies to medications, latex

etc.: _____

VI. WOMEN ONLY:

- | | | | |
|------------|--|------------|-----------------------------|
| 65. Yes No | Are you or could you be pregnant or nursing? | 66. Yes No | Taking birth control pills? |
|------------|--|------------|-----------------------------|

VII. ALL PATIENTS:

67. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?

If so, please explain: _____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient's signature: _____ Date: _____

RECALL REVIEW:

1. Patient's signature _____ Date: _____

2. Patient's signature _____ Date: _____

Patient Information

Patient Name: _____ Date: _____

Last, First MI (Preferred Name)

Gender: M / F

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Email Address: _____

Address: _____

Street Apartment #

City State Zip Code

Contact Information

• Name of Physician: _____ Phone: _____

• Pharmacy _____ Phone _____

• Emergency contact person? _____ Relation? _____ Phone _____

Insurance Subscriber's Information

The following is for: self spouse parent/guardian

Name: _____

Male Female

Name of Dental Insurance: _____ Secondary Insurance Name: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Subscriber's Employer: _____

Address of Subscriber: _____

Patient Employment Information

Employer Name: _____ Occupation: _____

Address: _____

Street City State Zip Code Phone

Referral Information

Whom may we thank for referring you to our practice? Another patient/friend Relative

Dental Office Yellow Pages Newspaper School Work Other

Name of person or office referring you to our practice: _____

Authorization and Release

I authorize Fernando Barrera, D.D.S. to release information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payors and/or other health care providers. Additionally, I authorize photocopies of this form to be as valid as the original. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I agree to pay my estimated co-pay amount at each visit. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. If benefits for services are sent to me for an unpaid balance, such checks are to be endorsed to Barrera Dental, P.C. as payment on my account.

I am aware that any unpaid balance my insurance company does not cover must be paid in full within 30 days unless other arrangements have been made with the office. I am aware that a monthly finance charge will accrue for any balance over 90 days not to exceed 10.5% yearly. I am also aware that failure to make my payments as agreed upon may result in legal or collection action to recover said amounts and any legal fees, court costs, and/or collection fees incurred in this process will be added to my account balance.

I have read the above conditions of treatment and payment and agree to their content.

Name _____ Date _____ Relationship to Patient _____