HEALTH HISTORY

DAVID R. DELONG, DDS
SMILES WITH STYLE

NAME _____ SINGLE _____ MARRIED _____ DIVORCED _____ SEPARATED _____ WIDOWED _____

NAME OF SPOUSE _____ HOME PHONE _____ YOUR SOCIAL SECURITY # _____

RESIDENCE ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMPLOYED BY _____ CITY _____ STATE _____ BUSINESS PHONE _____

PRESENT POSITION _____ HOW LONG HELD _____ YOUR DRIVER LICENSE NO. _____ STATE _____

SPOUSE EMPLOYED BY _____ CITY _____ STATE _____ BUSINESS PHONE _____

PRESENT POSITION _____ HOW LONG HELD _____ SPOUSE'S SOCIAL SECURITY # _____

REFERRED BY _____ ADDRESS _____

WHO WILL PAY FOR THIS ACCOUNT? _____

NAME OF YOUR DENTAL INSURANCE COMPANY _____ POLICY NO. _____ GROUP NO. _____

E-MAIL _____

It is important that I know about your dental and medical history. Many things have a direct bearing on your dental health. I will review the questionnaire and discuss it with you in detail. information you give me is strictly confidential and will not be released to anyone without your written permission.

MEDICAL HISTORY

PHYSICIAN'S NAME _____ Date of last physical exam _____

Birthdate _____ Age _____

Do you have or have you had any of the following? Please indicate with a check mark.

Yes / No		Yes / No		Yes / No		Yes / No	
___ / ___	Any heart problems	___ / ___	Allergies to anesthetics	___ / ___	Hepatitis	___ / ___	Sinus Problems
___ / ___	High Blood Pressure	___ / ___	Allergies to Medicines	___ / ___	Herpes	___ / ___	Stroke
___ / ___	Low Blood Pressure	___ / ___	or drugs	___ / ___	Malignancies	___ / ___	Typhoid Fever
___ / ___	Tonsillitis	___ / ___	Circulatory Problems	___ / ___	Allergies to	___ / ___	Measles
___ / ___	NervousProblems	___ / ___	Anemia	___ / ___	Mumps	___ / ___	Tuberculosis
___ / ___	Radiation Treatments	___ / ___	Arthritis	___ / ___	Psychiatric Care	___ / ___	Ulcer
___ / ___	Excessive Bleeding	___ / ___	Asthma	___ / ___	Rheumatic Fever	___ / ___	Venereal Disease
___ / ___	AIDS	___ / ___	Diabetes	___ / ___	Scarlet Fever	___ / ___	Other
___ / ___	Are you pregnant	Blood Pressure: S ____ / D ____		___ / ___	Osteoporosis	___ / ___	Bisphosphonates

Please describe any current medical treatment, impending operations, or any other dental information that may possibly affect your dental treatment.

_____

_____

_____

I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

Date _____ Your Signature _____

DENTAL HEALTH HISTORY

Please check any of the following problems that apply to you.

- ☐ Sensitivity (hot, cold, sweet)
- ☐ Tooth pain or discomfort when chewing
- ☐ Headaches, earaches, neck pain
- ☐ Jaw joint pain
- ☐ Teeth or fillings breaking
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen or irritated gurus
- ☐ Loose, tipped or shifting teeth
- ☐ Bad breath or bad taste in your mouth

Do you have or have you had any of the following?

- ☐ Dentures
- ☐ Partial dentures
- ☐ Braces
- ☐ Periodontal (gum) treatments

Please share the following dates:

Your last cleaning _____ /_____
Your last oral cancer screening _____ /_____
Your last complete X-Rays _____ /_____

PREVIOUS DENTIST

Name: _____

City: _____ State: _____

Phone Number: _____

If you could whiten your teeth for a cost anyone could afford, would you do it?

_____

Do you smoke or use chewing tobacco? How much? For how long?

_____

If you could change your smile, you would:

- ☐ Make them brighter
- ☐ Make them straighter
- ☐ Close spaces
- ☐ Replace black metal fillings with natural,
- ☐ tooth-colored fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover

On a scale of 1-10, with 10 the highest rating:

How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10
Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?

_____

_____

What is the most important thing to you about your future smile and dental health?

_____

_____

What is the most important thing to you about your dental visit today?

_____