Health History

Page 1

Welcome to

KEELAN DENTAL

Patient Information

Please input the patient's information below.
If you are completing this form on behalf of the patient, please also complete the "Legal Guardian" section on page 6.

First Name *

Last Name *

MI

Patient's Preferred Name

Date of Birth *

mm/dd/yyyy

Social Security Number

___-__-____

Gender *

○ Female ○ Male

Family Status *

☐ Married ☐ Single
☐ Child ☐ Other

Primary Phone Number *

(___) ___-____

Secondary Phone Number

E-Mail Address

Mailing Address *

City *

State *

__

Zip Code *

_____

Emergency Contact Name *

Emergency Contact Phone Number *

Relation to Emergency Contact *

Whom may we thank for referring you to our office? *

Does the patient have dental insurance? *

○ Yes ☐ No

If you answered yes, please continue to page 2.
If you answered no, please skip to page 3.

Insurance Information

Name of Dental Insurance Company

Insurance Company's Phone Number

(___) ___-____

Member ID Number

Group Number

Is the patient the insurance subscriber?

○ Yes ☐ No

If you answered no, please provider the subscriber's information below.
If you answered yes, please skip to page 3.

Subscriber's Name

Subscriber's Date of Birth

mm/dd/yyyy

Subscriber's SSN

Subscriber's Phone Number

(___) ___-____

Subscriber's E-Mail Address

Subscriber's Relationship to Patient

Subscriber's Mailing Address

City

State

__

Zip Code

_____

Subscriber's Employer

Phone Number of Subscriber's Employer

(___) ___-____

Comments:

Medical History

Name of Primary Care Physician

Phone Number of Physician
(___) ___-____

Date of Last Exam
mm/dd/yyyy

Name of Specialty Provider

Phone Number of Specialist
(___) ___-____

Date of Last Exam
mm/dd/yyyy

How would you rate your overall health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor *

Have you ever been hospitalized? *
○ Yes ☐ No

If yes, please explain.

Are you subject to frequent headaches? *
○ Yes ☐ No

If yes, please explain.

Are you currently or could you be pregnant? *
○ Yes ☐ No

If pregnant, what is your due date?

Do you currently smoke, vape, or use smokeless tobacco? *
☐ Smoke ☐ Vape ☐ Smokeless Tobacco
☐ Not Applicable

If yes, how many years have you smoked, vaped, and/or used smokeless tobacco?

If yes, how often do you smoke, vape, or use smokeless tobacco?

Do you currently drink alcohol? *
○ Yes ☐ No

If yes, please select appropriate response.
☐ Less than 1 drink per month
☐ 1-3 drinks per month
☐ 1-3 drinks per week
☐ 1-3 drinks per day

Comments

Allergies (Check all that apply)

☐ Acetaminophen
☐ Aspirin
☐ Ceclor
☐ Codeine
☐ Doxycycline
☐ Erythromycin
☐ Fluoride
☐ Ibuprofen
☐ Iodine
☐ Keflex
☐ Latex
☐ Local Anesthesia with Epinephrine
☐ Metals
☐ Penicillin
☐ Sulfa
☐ Tetracycline
☐ Not Applicable

*

Please explain any unlisted allergies.

Medical Conditions (Check any that you have at present or have had in the past)

- [ ] ACE Inhibitor
- [ ] AIDS
- [ ] Anemia
- [ ] Arthritis
- [ ] Artificial Joints
- [ ] Asthma
- [ ] Autoimmune Disease
- [ ] Back Problems
- [ ] Blood Disease
- [ ] Cancer - Existing
- [ ] Cancer - Melanoma
- [ ] Cancer - Treated
- [ ] Cholesterol
- [ ] Depression
- [ ] Diabetes
- [ ] Epilepsy
- [ ] Excessive Bleeding
- [ ] Fainting/Seizures
- [ ] Glaucoma
- [ ] Gout
- [ ] Head Injuries
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Hepatitis A
- [ ] Hepatitis B
- [ ] Hepatitis C
- [ ] High/Low Blood Pressure
- [ ] HIV
- [ ] HPV
- [ ] Jaundice
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Lumps in Mouth
- [ ] Mental Disorders
- [ ] Mitral-Valve Prolapse
- [ ] Multiple Sclerosis
- [ ] Nervous Disorders
- [ ] Pacemaker
- [ ] Radiation Treatment *
- [ ] Rheumatic Fever
- [ ] Sinus Issues
- [ ] STD
- [ ] STI
- [ ] Stomach Issues
- [ ] Stomach Ulcers
- [ ] Stroke
- [ ] Thyroid Issues
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Venereal Disease
- [ ] Not Applicable

Please explain any unlisted medical conditions.

Medications (Check all that apply)

- [ ] Birth Control
- [ ] Blood Thinners
- [ ] Dietary Supplements
- [ ] Erectile Dysfunction Medication
- [ ] Fosamax
- [ ] Osteoporosis Medication
- [ ] Premedication
- [ ] Weight Control
- [ ] Not Applicable

*

If you are taking medication, please explain.

List additional medications, supplements, and/or vitamins taken within the last two years:

Describe any current medical treatment, impending surgery, or other treatment.

Dental Information

How would you rate the condition of your mouth? *

- [ ] Excellent
- [ ] Good
- [ ] Fair
- [ ] Poor

How often do you see the dentist? *

- [ ] Every 3 months
- [ ] Every 4 months
- [ ] Every 6 months
- [ ] Every 12 months
- [ ] Not Routinely

What is your immediate concern? (Use the back of this page if more space is needed)

How fearful of the dentist are you? *

- [ ] Not Fearful
- [ ] Some Fear
- [ ] Very Fearful
- [ ] Require Sedation

Name of Previous Dentist Office

How many years were you a patient there?

Date of Most Recent Dental Exam

mm/dd/yyyy

Date of Most Recent Dental X-Rays

mm/dd/yyyy

Personal History (Check all that apply) *

- [ ] Had an unfavorable dental experience
- [ ] Had complications from past dental treatment
- [ ] Had trouble getting numb
- [ ] Had any reactions to local anesthetic
- [ ] Have/had braces or orthodontic treatment
- [ ] Had your bite adjusted
- [ ] Had any teeth removed
- [ ] Not Applicable

Smile Characteristics (Check all that apply) *

- [ ] Is there anything about the appearance of your teeth that you would like to change?
- [ ] Have you ever whitened (bleached) your teeth?
- [ ] Have you ever felt uncomfortable or self-conscious about the appearance of your teeth?
- [ ] Have you ever been disappointed with the appearance of previous dental work?
- [ ] Not Applicable

Tooth Structure (Check all that apply.) *

- [ ] Cavities within past 3 years
- [ ] The amount of saliva in your mouth seems too little or you have difficulty swallowing any food
- [ ] You notice or have holes (i.e. pitting, craters) on the biting surface of your teeth
- [ ] Any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth
- [ ] Grooves or notches on your teeth, chipped teeth, or had a toothache or cracked filling
- [ ] Food gets caught between any teeth
- [ ] Not Applicable

Gum and Bone (Check all that apply.) *

- [ ] Gums bleed when brushing or flossing
- [ ] Treated for gum disease or were told you have lost bone around your teeth
- [ ] Noticed an unpleasant taste or odor in your mouth
- [ ] History of periodontal disease in your family
- [ ] Experienced gum recession
- [ ] Had any teeth become loose on their own (without injury) or have difficulty eating an apple
- [ ] Experienced a burning sensation in your mouth
- [ ] Not Applicable

Bite and Jaw Joint (Check all that apply.) *

- [ ] You have problems with your jaw joint
- [ ] You have any problems chewing
- [ ] Your teeth changed in the last 5 years, became shorter, thinner, or worn
- [ ] Your teeth crowding or developing spaces
- [ ] Not Applicable

- [ ] You chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits
- [ ] You clench you teeth in the daytime or make them sore
- [ ] You have problems with sleep or wake up with an awareness of your teeth
- [ ] You wear or have worn a bite appliance
- [ ] Not Applicable

If any of the checked boxes need further explanation, please explain.

Legal Guardian Information

Please input information of patient's legal guardian.

First Name | Last Name | MI | Preferred Name

Date of Birth | Social Security Number | Relation to Patient

Phone Number | Secondary Phone Number | E-Mail Address

Mailing Address

City | State | Zip Code

Person Responsible for Payment Information

Please input information of the person who is responsible for payment if different than the patient or legal guardian.

First Name | Last Name | MI | Preferred Name

Date of Birth | Social Security Number | Relation to Patient

Phone Number | Secondary Phone Number | E-Mail Address

Mailing Address

City | State | Zip Code

Acknowledgement

☐ By checking this box, I acknowledge that the above information is correct. I understand that it is my responsibility to inform Keelan Dental of any changes to this information. *

Today *

mm/dd/yyyy

Signature *