ADULT HEALTH HISTORY

Please email completed PDF files to: info@washougalfamilydental.com

Washougal Family Dental

To help us meet all your dental healthcare needs, please fill out this form completely.

1 Patient Information

Today's Date: _____

Name: _____

I prefer to be called: _____ Male Female

Birthdate: _____ Age: _____ SS#: _____

E-mail Address: _____

May we send you monthly newsletters via email? Y N

Home Address: _____

_____

Single Married Divorced Widowed Separated

Hm #: _____ Pager / Cell #: _____

Wk #: _____ Ext:____ DL #: _____

Employer: _____

Employer's Address: _____

_____

How long there?_____ Occupation: _____

Where and when are the best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____

Last visit date: _____

2 Spouse Information

His / Her Name: _____

Employer: _____

Wk #: _____ Ext: ____ SS #: _____

Birthdate: _____ DL #: _____

Person Responsible for Account: _____

Wk #: _____ Ext: ____ Hm #: _____

Billing Address: _____

Relation:_____ SS #: _____

Employer: _____DL #: _____

3 Dental Insurance

PRIMARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____ Insured's ID #:_____

Insured's Employer: _____

SECONDARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____ Insured's ID #:_____

Insured's Employer: _____

4 Medical History

Do you have a personal physician? Y N

Physician's Name: _____

Phone:_____ Last visit date:_____

Are you currently under the care of a physician? Y N

Please explain: _____

In the event of an emergency, is there someone who lives near you that we should contact?

His / Her Name: _____ Relation: _____

Wk #: _____ Hm #: _____

Continued on next page.

5 Medical History

CONTINUED

Your current physical health is: GOOD FAIR POOR

Do you smoke or use tobacco in any form? Y N
If yes, how much a day and for how long? _____

Are you taking any prescription /over-the-counter or herbal supplemental drugs? Y N

Please list each one: _____

_____

Have you ever taken Fosamax, or any other bisphosphonate? Y N

Have you ever taken Phen-fen? Y N

FOR WOMEN: Are you using a prescribed method of birth control? Y N

Are you pregnant? Y N Week #: _____

Are you nursing? Y N

Have you ever had any of the following diseases or medical problems?

	YES	NO		YES	NO
Abnormal Bleeding			Herpes/Fever Blisters		
Alcohol/Drug Abuse			High Blood Pressure		
Anemia			HIV+/AIDS		
Arthritis			Kidney Problems		
Artificial Bones/ Joints/Valves			Liver Disease		
Asthma			Low Blood Pressure		
Blood Transfusion			Lupus		
Cancer/Chemo			Mitral Valve Prolapse		
Colitis			Pacemaker		
Congenital Heart Defect			Psychiatric Problems		
Diabetes			Radiation Treatment		
Difficulty Breathing			Rheumatic/Scarlet Fever		
Emphysema			Seizures		
Epilepsy			Shingles		
Fainting Spells			Sickle Cell Disease		
Frequent Headaches			Sinus Problems		
Glaucoma			Stroke		
Hay Fever			Thyroid Problems		
Heart Attack			Tuberculosis (TB)		
Heart Murmur			Ulcers		
Heart Surgery			Venereal Disease		
Hemophilia			Hospitalized for Any Reason		
Hepatitis			Y N If yes, please explain:		

Please list any medical conditions that you have ever had:

_____

Are you allergic to any of the following?

	YES	NO		YES	NO
Aspirin			Latex		
Codeine			Penicillin		
Dental Anesthetics			Tetracycline		
Erythromycin			Other		
Jewelry/Metals					

Please list any other drugs/materials that you are allergic to:

_____

_____

6 Dental History

Why have you come to the dentist today?

_____

_____

Has your doctor told you that you require antibiotics before dental treatment? Y N

Are you currently in pain? Y N

Have you ever had a serious / difficult problem associated-with any previous dental work? Y N

Do you have or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD) Y N

Your current dental health is: GOOD FAIR POOR

Do you like your smile? Y N

Do your gums ever bleed? Y N

How many times a week do you floss? _____

How many times a day do you brush? _____

Type of bristles? HARD MEDIUM SOFT

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have a question at any time, please ask us. We are happy to help. Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

SIGNATURE DATE

If filling out and submitting PDF online:
Typed initials, and first name/last name is sufficient for approval.