DENTAL HEALTH HISTORY
(Confidential)

Patient Name ____ Today's Date ______________
Last First Initial

DENTAL HISTORY

Reason for today's visit ____

Former Dentist ______________________________________ Phone ______________

Address ____

Date of last dental care ____________________ Date of last dental x-rays ____________________

Check (✓) if you have any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding Teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss? ____________________ How often do you brush? ____________________

MEDICAL HISTORY

Physician's Name ______________________________________ Date of Last Visit ______________

Address ______________________________________ Phone ______________

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe ____________________

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates ____________________

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have ever had any of the following:

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems, describe:

  ____

  ____

  ____
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

ALLERGIES

☐ Aspirin ☐ Codeine ☐ Latex ☐ Penicillin

☐ Barbiturates (Sleeping pills) ☐ Local Anesthetic

☐ Other ______________________________

____

MEDICATIONS

List medications you are currently taking: ______________

____

Pharmacy Name ______________________________

Phone ______________________________

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date ______________ Signature ______________________________

PATIENT INFORMATION

Name ____ Soc. Sec. #: ____________________
Last First Initial

Address ____

Phone #ǯs: Home____________________ Cell ____________________ Work ____________________ Ext ______

Gender: ☐ M ☐ F Age ___ Birthdate ______________ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient employed by ____ Occupation ____________________

Business Address ____ Business Phone ____________________

In case of emergency, who should be notified? ______________________________ Phone ____________________

Whom may we thank for referring you? ____

PRIMARY DENTAL INSURANCE

Person Responsible for Account ____
Last First Initial

Relation to Patient ______________________________ Birthdate ____________ Soc. Sec. # ____________________

Address____ Phone ____________________

City____ State ____________________ Zip ________

Person responsible employed by ____ Occupation ____________________

Business Address____Business Phone ____________________

Insurance Company ____

Contract # ______________________________ Group # ____________________ Subscriber # ____________________

Names of other dependents covered under this plan ____

SECONDARY DENTAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriberǯs Name ________________________ Relation to Patient ______________ Birthdate ____________________

Address ____Phone ____________________

City____ State ____________________ Zip ________

Subscriber employed by ____ Business Phone ____________________

Insurance Company ____ Soc. Sec. # ____________________

Contract # ______________________________ Group # ____________________ Subscriber # ____________________

Names of other dependents covered under this plan ____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with ______________________________
Name of Insurance Company(ies)

and assign directly to Dr. Daniel C. Shomer, D.M.D. all insurance benefits, if any, otherwise payable to me for services rendered.

I understand that I am financially responsible for all charges for myself and/or all dependents whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____ ______________________________ ____________________
Responsible Party Signature Relationship Date

~ Please Note ~ Co-Pays must be paid on day of treatment ~