Health History

Patient Name: _____ Date:
Date of Last Dental Visit: _____Reason for today's visit: _____
Former Dentist _____ Name of Office _____
Are you in good health? ☐ Yes ☐ No If no, please explain:_____
Are you currently feeling any pain? ☐ Yes ☐ No If yes, please describe:_____
Has there been any change in you general health this past year? ☐ Yes ☐ No
Have you ever or do you have any of the following? Please check all those that apply:

- ☐ Acid Reflux
- ☐ AIDS/HIV Positive
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Bacterial Endocarditis
- ☐ Blood Disease
- ☐ Bruise Easily
- ☐ Cancer – Type:_____ yr diag.____
- ☐ Cold Sores/Fever Blisters
- ☐ Diabetes
- ☐ Dizziness/Fainting/Frqnt. Headaches
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis A,B, or C
- ☐ High ☐ Low Blood Pressure
- ☐ Hypoglycemia
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorder
- ☐ Pacemaker
- ☐ Pain in Jaw/Joints
- ☐ Renal Dialysis
- ☐ Sinus Problems
- ☐ Snoring/Sleep Apnea
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tobacco Use
- ☐ Tuberculosis

ALLERGIES:

- ☐ Latex
- ☐ Codeine
- ☐ Penicillin
- ☐ Acrylic
- ☐ Metals/Jewelry
- ☐ Local Anesthetics

Other Allergies (Including Drug)**:**

- ☐ _____
- ☐ _____

STAFF USE ONLY:

☐ MEDICAL ALERT / RECORDED
_____
_____
_____
_____
_____
_____
_____

☐ PRE-MED POP-UP / CREATED
_____
_____
_____
_____
_____

MEDICATIONS: *Are you taking any of the following? Please list:* **(STAFF USE ONLY: ☐ MEDICAL ALERT RECORDED)**

- ☐ Antibiotics? _____
- ☐ Anticoagulants (blood thinners)? _____
- ☐ Aspirin or drugs such as Motrin, Aleve, Ibuprofen? _____
- ☐ High blood pressure medications? _____
- ☐ Steroids (Cortisone, etc.)?_____
- ☐ Insulin or anti-diabetic drugs? _____
- ☐ Digitalis, Inderal, Nitroglycerine, or other heart drug? _____
- ☐ Tranquilizers?_____

Other Medications:_____

Have you ever been advised to pre-medicate before dental procedures? ☐ Yes ☐ No Reason/Date_____

Are you or *have you ever taken* Bisphosphonates: (FOSAMAX, ACTONEL OR BONIVA for osteoporosis, Aredia or Zometa for various cancers, etc.)? ☐ Yes ☐ No

FOR WOMEN ONLY:

Are you pregnant, or is there any chance you might be? ☐ ***Yes*** ☐ ***No*** Are you nursing? ☐ ***Yes*** ☐ ***No***
If you are using Oral Contraceptives, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

- Have you ever had any complications following dental treatment?
  ☐ ***Yes*** ☐ ***No*** If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years?
  ☐ ***Yes*** ☐ ***No*** If yes, please explain: _____
- Are you currently under the care of a physician?
  ☐ ***Yes*** ☐ ***No*** If yes, please explain: _____
- Name of Physician: _____ Phone: _____

Doctor notes:_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ **Date**_____

Signature of patient, parent, or guardian

Patient Registration & Health History

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)
Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Cell):_____ (Work): ____

Address: _____
Street Apartment #

_____
City State Zip Code

E-mail Address:_____

In the event of an emergency, whom should we contact? *Please list someone NOT living with you*.

Name_____ **Phone:**_____ **Relationship to you**_____

Responsible Party/Employment Information

Name:_____

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name_____ Occupation: _____

Address: _____
Street City Zip Code Phone

Insurance Information

Name of Insured: _____ Is the insured a patient? ☐ Yes ☐ No

Insured's Birth Date: _____ ID# or SS#: _____ Group #:_____

Insured's Address:_____
Street City State Zip Code

Insured's Employer Name and Address:_____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address:_____

How did you find out about Lighthouse Dental? (check more than one if more than one applies)

☐ Office location ☐ Friend/Relative ☐ Website ☐ Insurance Carrier ☐ Letter ☐ Other:_____
Whom may we thank for referring you to our practice:_____