Health History Form

Date ____________

Name ____________ Home Phone (___) ________ Cell (___) ________ Work (___) ________

Address ____________ City ____________ State ________ Zip Code ________

E-mail Address ____________ ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Occupation ____________ Height ______ Weight ______ Date of Birth ________ Sex ☐ M ☐ F

SS# ____________ Emergency Contact ____________ Relationship ____________ Phone (___) ________

If you are completing this form for another person, what is your relationship to this person? ____________
Name Relationship

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

INSURANCE INFORMATION

INSURED PERSON'S FULL NAME ____________ INSURED PERSON D.O.B ____________

SOCIAL SECURITY NUMBER ____________ RELATIONSHIP TO PATIENT ____________ WORK PHONE ____________

INSURANCE COMPANY NAME ____________ GROUP OR LOCAL NUMBER ____________

EMPLOYER NAME ____________ FULL ADDRESS OF EMPLOYER ____________

I authorize insurance payment directly to Dr. Shelly M. Galvin. I understand that I am ultimately responsible for all charges whether paid by my insurance or not. I authorize Dr. Shelly M. Galvin to release information required to secure the benefits.

DENTAL INFORMATION

Signature of Responsible Party: ____________

YES	NO	DON'T KNOW	
☐	☐	☐	Do your gums bleed when you brush?
☐	☐	☐	Are your teeth sensitive to cold, hot, sweets, or pressure?
☐	☐	☐	Have you had any periodontal (gum) treatments?
☐	☐	☐	Have you had any serious/difficult problem associated with any previous dental treatment? If so, explain ____________
☐	☐	☐	Have you ever had orthodontic treatment?
☐	☐	☐	Do you have headaches, earaches or neck pains?
☐	☐	☐	Do you wear removable dental appliances?

How would you describe your current dental problem? ____________ Family history of Periodontal Disease ______

Date of your last dental exam ________ Date of last hygiene appt ________ Name of last dentist ____________

What was done at that time? ____________ Date of last dental x-rays ____________

How do you feel about the appearance of your teeth? ____________ Do you have any problems with bad breath? ________

MEDICAL INFORMATION

YES	NO	DON'T KNOW	
☐	☐	☐	Are you in good health?
☐	☐	☐	Has there been any changes in your health within the past year?
☐	☐	☐	Are you under the care of a physician? If so, what are the conditions being treated? ____________ Date of last exam ________

Physician ____________
Name Phone Address City/State/Zip

YES	NO	DON'T KNOW	
☐	☐	☐	Have you ever had any serious illness, operation, or been hospitalized in the past five years? If so, what was the illness or problem? ____________
☐	☐	☐	Do you drink soft drinks / sports drinks? If yes how many per day? ________
☐	☐	☐	Do you drink alcoholic beverages? If yes, how much alcohol did you drink in the past week? ______ Month? ______ If yes, ______ # drinks per day for ______ # of years
☐	☐	☐	Are you alcohol and/or drug dependent? If so have you received treatment? (Check one) ☐ YES ☐ NO
☐	☐	☐	Do you use drugs or other substances for recreational purposes? If yes, please list ____________
☐	☐	☐	Do you use tobacco (smoking or chew)? If so, how interested are you in quitting? ☐ Very ☐ Somewhat ☐ Not at all How many years have or did you use tobacco? ______ How much tobacco did you use per day? ________