Dental Patient Health History Form

Please complete all sections of this health history form. This information is essential for providing safe and effective dental care.

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1. Patient Information

Full Name:		Date of Birth:	MM/DD/YYYY
Phone Number:		Email Address:	
Street Address:			
Emergency Contact Name:		Emergency Contact Phone:	

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2. Medical History

Primary Care Physician:		Physician Phone:	
Date of Last Physical Exam:			
Are you in good health? (Yes/No):		Any recent medical changes? (Yes/No):	
Are you pregnant? (Yes/No/NA):		Are you nursing? (Yes/No/NA):	

Please list "Yes" or "No" for the following conditions:

Heart Disease / Conditions:		High Blood Pressure:	
Diabetes:		Asthma / Lung Disease:	
Allergies (latex, penicillin, etc.):		Bleeding Disorders:	
Hepatitis / Liver Disease:		Epilepsy / Seizures:	

List any current medications, drugs, or pills you are taking:

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3. Dental History

Reason for today's visit:			
Date of last dental visit:		Date of last dental X-rays:	
Do your gums bleed? (Yes/No):		Are your teeth sensitive? (Yes/No):	
Do you feel nervous about dental care? (Yes/No):			

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4. Acknowledgement and Signature

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Signature of Patient, Parent, or Guardian: Date: