Nevada Dental Benefits, Ltd.®

a PRIMECARE℠ BENEFITS company

HEALTH HISTORY FORM

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answer are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

USER INFORMATION

Last Name	First Name	Middle Name
City	State	Zip Code

Height	Weight	DOB	Sex ☐ Male ☐ Female

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

Do you have any of the following diseases or problems (Check DK if you don't know the answer to the question)

	Yes	No	DK
Active tuberculosis	☐	☐	☐
Persistent cough greater than 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this from to the receptionist

DENTAL INFORMATION

For the following questions, please mark (✓) your responses to the following questions

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatment?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problem associated with previous dental treatment	☐	☐	☐
Are you currently experiencing dental pain or discomfort?	☐	☐	☐
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐

	Yes	No	DK
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam

What was done at that time?

Date of your last dental x-rays

What is the reason for your dental visit today?

How do you feel about your smile?

MADICAL INFORMATION

Please mark (✓) your response to indicate if you have or have not had any of yhe following diseases or problems

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐

Physician Name

Address

City	State
Zip Code	Phone # (with area code)

	Yes	No	DK
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

	Yes	No	DK
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements

Date of last physical exam

	Yes	No	DK
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? Date________________ If yes, have you had any complications?	☐	☐	☐
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax*, Actonel*, Atelvia, Boniva*, Reclast, Prolia) for osteoporosis or paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently, scheduled to begin treatment with an antiresorptive agent (like Aredia*, Zometa*, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from paget's disease, multiple myeloma or metastatic cancer? Date Treatment began________________	☐	☐	☐
Do you use controlled substances (drugs)?	☐	☐	☐

	Yes	No	DK
Do you use tobacco (smoking, snuff, chew, bidis)? If so, how interested are you in stopping? ○ Very ○ Somewhat ○ Not Interested	☐	☐	☐
Do you drink alcoholic beverages? If yes, how much alcohol did you drink in the last 24 hours? if yes, how much do you typically drink in a week?	☐	☐	☐
Women only are you:			
Pregnant?	☐	☐	☐
Number of weeks			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies. Are you allergic to or have you had a reaction to:
(Please list any allergies and type of reaction for each.)

To all **yes** responses, specify type of reaction.

	Yes	No	DK		Yes	No	DK
Local Anesthetic	☐	☐	☐	Penicillin or other antibiotics	☐	☐	☐
Metals	☐	☐	☐	Codeine or other narcotics	☐	☐	☐
Latex (Rubber)	☐	☐	☐				

Please mark (✓) your response to indicate if you have or have not had any of the following diseases or problems:

	Yes	No	DK		Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐	**Congenital heart disease (CHD)**			
Previous infective endocarditis	☐	☐	☐	Unrepaired, cyanotic CHD	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐	Repaired (completely) in last 6 months	☐	☐	☐
				Repaired CHD with residual defects	☐	☐	☐

	Yes	No	DK
Have you had surgery on your heart?	☐	☐	☐
Have you had an infection in your heart?	☐	☐	☐
Heart murmur	☐	☐	☐
Other heart disease	☐	☐	☐
Pacemaker	☐	☐	☐
High blood pressure	☐	☐	☐
Heart Attack	☐	☐	☐
High Cholesterol	☐	☐	☐
Glaucoma	☐	☐	☐
Other Eye disease	☐	☐	☐
Do you wear glasses or contact lenses?	☐	☐	☐

	Yes	No	DK
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion If yes, date: __________	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐
Autoimmune disorders: Such as: Rheumatoid Arthritis & Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Trouble breathing / Lung disorder	☐	☐	☐
Sinus trouble	☐	☐	☐

	Yes	No	DK
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐

	Yes	No	DK
Neurological disorders If yes, specify:	☐	☐	☐
Sleep disorder	☐	☐	☐
Do you snore?	☐	☐	☐
Mental health disorders Specify:	☐	☐	☐
Recurrent infections Type of infection:	☐	☐	☐
Kidney problems	☐	☐	☐
Osteoporosis	☐	☐	☐
Severe headaches/migraines	☐	☐	☐
Sexually transmitted disease	☐	☐	☐

	Yes	No	DK
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐

Name of physician or dentist making recommendation:	Phone # (with area code)

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about in quires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian

Date mm/dd/yy