ADA. American Dental Association
www.ada.org

Medical Alert:	Condition:	Premedication:	Allergies:	Anesthesia:	Date:

HEALTH HISTORY FORM

Name: (LAST FIRST MIDDLE) Home Phone: ( ) Business Phone: ( )

Address: (P.O. BOX or Mailing Address) City: State: Zip Code:

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 that person?

NAME RELATIONSHIP

For the following questions, please (X) whichever applies, your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit 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.

DENTAL INFORMATION

	Yes	No	Don't Know
Do your gums bleed when you brush?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Do you have earaches or neck pains?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Do you wear removable dental appliances?	☐	☐	☐
Have you had a serious/difficult problem associated with any previous dental treatment?	☐	☐	☐

If yes, explain:

How would you describe your current dental problem?

Date of your last dental exam:

Date of last dental x-rays:

What was done at that time?

How do you feel about the appearance of your teeth?

MEDICAL INFORMATION

	Yes	No	Don't Know
If you answer yes to any of the 3 items below, please stop and return this form to the receptionist.			
Have you had any of the following diseases or problems?			
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐
Are you now under the care of a physician?	☐	☐	☐

If yes, what is/are the condition(s) being treated?

Date of last physical examination:

Physician:

NAME PHONE

ADDRESS CITY/STATE ZIP

NAME PHONE

ADDRESS CITY/STATE ZIP

Have you had any serious illness, operation, or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

	Yes	No	Don't Know
Are you taking or have you recently taken any medicine(s) including non-prescription medicine?	☐	☐	☐

If yes, what medicine(s) are you taking?

Prescribed:

Over the counter:

Vitamins, natural or herbal preparations and/or diet supplements:

Are you taking, or have you taken, any diet drugs such Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)?	☐	☐	☐
Do you drink alcoholic beverages?	☐	☐	☐

If yes, how much alcohol did you drink in the last 24 hours?

In the past week?

Are you alcohol and/or drug dependent?	☐	☐	☐

If yes, have you received treatment? (circle one) Yes / No

Do you use drugs or other substances for recreational purposes?	☐	☐	☐

If yes, please list:

Frequency of use (daily, weekly, etc.):

Number of years of recreational drug use:

Do you use tobacco (smoking, snuff, chew)?	☐	☐	☐

If yes, how interested are you in stopping?
(circle one) Very / Somewhat / Not interested

Do you wear contact lenses?	☐	☐	☐

PLEASE COMPLETE BOTH SIDES

Are you allergic to or have you had a reaction to?	Yes	No	Don't Know
Local anesthetics	☐	☐	☐
Aspirin	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐	☐
Sulfa drugs	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Latex	☐	☐	☐
Iodine	☐	☐	☐
Hay fever/seasonal	☐	☐	☐
Animals	☐	☐	☐
Food (specify) _____	☐	☐	☐
Other (specify) _____	☐	☐	☐
Metals (specify) _____	☐	☐	☐

To yes responses, specify type of reaction. _____

	Yes	No	Don't Know
Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐

If yes, when was this operation done? _____

If you answered yes to the above question, have you had any complications or difficulties with your prosthetic joint? _____

	Yes	No	Don't Know
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐

If yes, what antibiotic and dose? _____

Name of physician or dentist*: _____

Phone: _____

WOMEN ONLY

Are you or could you be pregnant?	☐	☐	☐
Nursing?	☐	☐	☐
Taking birth control pills or hormonal replacement?	☐	☐	☐

Please (X) a response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	Don't Know
Abnormal bleeding	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Anemia	☐	☐	☐
Arthritis	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Asthma	☐	☐	☐
Blood transfusion. If yes, date: _____	☐	☐	☐
Cancer/Chemotherapy/Radiation Treatment	☐	☐	☐
Cardiovascular disease. If yes, specify below:	☐	☐	☐
____ Angina	____ Heart murmur		
____ Arteriosclerosis	____ High blood pressure		
____ Artificial heart valves	____ Low blood pressure		
____ Congenital heart defects	____ Mitral valve prolapse		
____ Congestive heart failure	____ Pacemaker		
____ Coronary artery disease	____ Rheumatic heart disease/Rheumatic fever		
____ Damaged heart valves			
____ Heart attack			
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Disease, drug, or radiation-induced immunosurpression	☐	☐	☐
Diabetes. If yes, specify below:	☐	☐	☐
____ Type I (Insulin dependent) ____ Type II			
Dry Mouth	☐	☐	☐
Eating disorder. If yes, specify: _____	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Glaucoma	☐	☐	☐

	Yes	No	Don't Know
Hemophilia	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Recurrent Infections	☐	☐	☐
If yes, indicate type of infection: _____			
Kidney problems	☐	☐	☐
Mental health disorders. If yes, specify: _____	☐	☐	☐
Malnutrition	☐	☐	☐
Night sweats	☐	☐	☐
Neurological disorders. If yes, specify: _____	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck			
Respiratory problems. If yes, specify below:	☐	☐	☐
____ Emphysema ____ Bronchitis, etc.			
Severe headaches/migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Sinus trouble	☐	☐	☐
Sleep disorder	☐	☐	☐
Sores or ulcers in the mouth	☐	☐	☐
Stroke	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Tuberculosis	☐	☐	☐
Thyroid problems	☐	☐	☐
Ulcers	☐	☐	☐
Excessive urination	☐	☐	☐

	Yes	No	Don't Know
Do you have any disease, condition, or problem not listed above that you think I should know about?	☐	☐	☐

Please explain: _____

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. I acknowledge that my questions, if any, about inquiries 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 _____

FOR COMPLETION BY DENTIST

Comments on patient interview concerning health history: _____

Significant findings from questionnaire or oral interview: _____

Dental management considerations: _____

Health History Update: On a regular basis the patient should be questioned about any medical history changes, date and comments notated, along with signature.

Date	Comments	Signature of patient and dentist

GIGI MEINECKE, D.M.D.

10520 MACARTHUR BOULEVARD
POTOMAC, MARYLAND 20850
TELEPHONE (301) 299-2925

Patient Registration

Patient's Name _____

Address _____ Apt. _____ Marital Status S M D

City _____ State _____ Zip Code _____

Home Phone ( ) _____ Work Phone ( ) _____ Cell Phone ( ) _____

Birthdate _____ Sex: Male Female SSN _____

Full-time Student: Yes No If yes, name of school attended: _____

Employer _____

Occupation _____

How did you hear about our practice? _____

Person Responsible for this Account (if different from above)

Relationship to Patient: ( ) Self ( ) Spouse ( ) Parent/Guardian If self, skip to Insurance Section

Name _____ Birthdate _____ Sex: M F

Does this person reside in the same household as the patient: Yes No

Address _____ Apt. _____

City _____ State _____ Zip Code _____

Home Phone ( ) _____ Work Phone ( ) _____ Cell Phone ( ) _____

SSN _____ Employer/Occupation _____

Is Patient Covered by Dental Insurance ( ) Yes ( ) No

Subscriber's Name _____ Birthdate _____ Sex: M F

SSN or Subscriber Number (shown on card) _____ Group Number _____

Employer's Name _____

Insurance Company _____

Insurance Company Address _____

Relationship to Patient: ( ) Self ( ) Spouse ( ) Parent/Guardian

Is the patient covered by any other dental insurance? Yes No If you answered yes, please note: We will, as a courtesy, submit an insurance claim to ONE dental insurance provider on your behalf for each visit. If you have benefits from any additional dental insurance plan, it is your responsibility to submit your completed claim forms directly to your other dental insurance provider(s).

NOTE:
Due to the constantly changing insurance rules and regulations, benefits and deductibles, we are only able to approximate your insurance balance. If your insurance pays more than expected, your account will be credited the difference. If your insurance company pays less than expected, you will be billed the difference. Final responsibility for payment rests with the person responsible for this account.

_____ _____

Date Signature/Relationship to Patient

Revised 9/2007

GIGI MEINECKE, D.M.D.

10520 MACARTHUR BOULEVARD
POTOMAC, MARYLAND 20850
TELEPHONE (301) 299-2925

Patient's Name _____

Parent's Name (if applicable): _____

Please list the phone numbers which we may use to contact you regarding appointments and/or treatment.

Home: _____

Work: _____

Cell: _____

E-mail address (optional): _____

_____ _____
Signature Date

GIGI MEINECKE, D.M.D.

10520 MACARTHUR BOULEVARD
POTOMAC, MARYLAND 20854
Telephone (301) 299-2925

Dear Doctor:

_____ has presented to this office for treatment. Please forward any radiographs and treatment records that may exist for this patient to the above address or to docgmeinecke@gmail.com (NO CORRESPONDENCE TO THIS EMAIL-XRAYS ONLY)

Thank you for your anticipated prompt response.

Gigi Meinecke, D.M.D.

_____ _____

Signature Date