D.A. DENTAL
DEMI ATHANS D.M.D.
Where Quality Meets Compassionate Care

Health History Form

Email: _____ Cell: (___)_____ Today's date: _____

The following information is vital to allow us to provide appropriate care for you. Your information will be kept confidential subject to applicable laws.

Last name: _____ First name: _____ MI: _____ Home Phone: (___)_____
Address: _____ City: _____ State: _____ Zip: _____
Date of Birth: _____ Gender: **M F** SSN: _____-___-____ Height: _____ Weight: _____
(Required for insurance claims)
Occupation: _____
If you are completing this form, what is your relationship to that person?
Your name: _____ Relationship _____

Do you have any of the following conditions? (Check DK if you don't know)	**Y**	**N**	**DK**
Active Tuberculosis (TB) _____	☐	☐	☐
Persistent cough (over 3 weeks) _____	☐	☐	☐
Cough that produces blood _____	☐	☐	☐
Are you under a physician's care? _____	☐	☐	☐
Have you been recently hospitalized? _____	☐	☐	☐
Do you use tobacco? _____	☐	☐	☐
Do you use controlled substances (please specify)? _____	☐	☐	☐
Do you use medicinal or recreational marijuana (please specify)? _____	☐	☐	☐
Do you take, or have you taken, oral or IV Biphosphonates like Boniva, Fosamax, Actonel, Reclast, Aredia or any other medication for Osteoprosis or to help increase bone density? _____	☐	☐	☐

Dental Information

(Check DK if you don't know)	**Y**	**N**	**DK**
Do your gums bleed while brushing or flossing?_____	☐	☐	☐
Are your teeth sensitive to hot, cold, sweet, or pressure? _____	☐	☐	☐
Do you grind/clench your teeth during the day or night (Please specify?) _____	☐	☐	☐
Do you have any jaw pain? _____	☐	☐	☐
Do you experience any clicking or popping of the TMJ? _____	☐	☐	☐
Do you wear a night guard? _____	☐	☐	☐
Do you wear dentures (full or partials)? _____	☐	☐	☐

Date of last dental visit: _____ Date of last dental X-rays: _____

Are you **allergic** to any medications? Please list: _____

Please list all medications you are **taking** (including supplements: _____

_____

Do you have or have you had any of the following?

	Y	N		Y	N		Y	N		Y	N
Cardiovascular Disease			Hemophilia			GI Disease			Convulsions		
Heart Attack			Bld. Transfusion			Gastric Ulcers			Headaches/Migraines		
Stroke			Blood Disorder			Malnutrition			Psychiatric Condition		
Congest. Heart Failure			HIV/AIDS			Eating Disorder			Glaucoma		
Congenital Heart Dis.			Autoimmune Dis.			Thyroid Disease			Osteoporosis		
Heart Murmur			Osteoarthritis			Kidney Disease			Rapid Weight Loss		
Low Blood Pressure			Rheum. Arthritis			Alcoholism			STD		
High Blood Pressure			Lupus			Drug Addiction			Night Sweats		
Mitral Valve Prolapse			Bronchitis			Diabetes- I & II			Excessive Urination		
Pacemaker			Asthma			Cancer			Smoking		
Artificial Heart Valve			COPD			Chemotherapy			Shingles		
Rheumatic Fever			Emphysema			Radiation			Artificial Joints		
Rheum. Heart Disease			Chr. Liver Dis.			Epilepsy			Alzheimer's Disease		
Excessive Bleeding			Cirrhosis			Seizures			Cortisone Therapy		
Anemia			Hepatitis B or C (circle type)			Fainting/Dizziness			Hay Fever		

Any other illness that is not listed above? If "yes," please explain: _____

_____

Preferred Pharmacy _____

Emergency contact: _____ Relationship: _____ Phone: (___)_____

For women only: Are you:

Pregnant/Trying to get pregnant? Y N Nursing? Y N Taking oral contraceptives? Y N

Acknowledgement

☐ ***I attest that the information given above is accurate and truthful. I understand that providing incorrect information or withholding information can be dangerous to my (or the patient's) health. It is my responsibility to inform D.A. Dental of any changes in the medical status.***

Print name: _____ Signature: _____

Parent or Guardian Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____