DR. E. DEAN POWELL
Health History Form

Welcome!

Whether you are a new, returning or current patient, we are happy to see you for your dental needs. We know that medications and medical history can change, including the addition of supplements that may affect the way your medications work. Therefore, in order to provide you with the best care possible, please fill out our medical history form and advise us of any changes in your medical history at each visit.

You can also attach a list of your medications and supplements to this form.

PLEASE PRINT UNLESS OTHERWISE INDICATED & CIRCLE ANSWERS AS NEEDED

1 ABOUT YOU

Today's Date: _____

Email Address: _____

Patient Full Name: _____
Last First

MI _____ Nickname _____

Male / Female ~~~ Mr. / Mrs. / Ms. / Dr.

Marital Status: Single / Married / Divorced
Legally Separated / Widowed

Birthdate: _____/_____/_____ Age: _____
Month Day Year

Social Security #: _____/_____/_____

Employer: _____

Employer's Address: _____

Occupation: _____

Home Address: _____

_____
City State Zip Code

Mailing Address (if different from home address):

_____

_____
City State Zip Code

Telephone: Home _____

Work _____ Ext. _____

Cell _____

Where & when are the best times to reach you?

_____

Do we have your permission to leave a message
(voice mail or with person answering phone)? Y N

Signature Required: _____

2 SPOUSE INFORMATION

His/Her Name: _____

Employer: _____

Social Security #: _____/_____/_____

Telephone:

Home _____ Cell _____

Work _____ Ext. _____

3 PERSON RESPONSIBLE FOR ACCOUNT

_____
Last First

MI _____ Nickname _____

Relationship: Self / Spouse / Father / Mother

Other (Please specify) _____

Billing Address: _____

_____
City State Zip Code

Birthdate: _____/_____/_____ Age: _____
Month Day Year

Email: _____

Employer: _____

Social Security #: _____/_____/_____

Telephone: Home _____

Work _____ Ext. _____

Cell #: _____

4 PRIMARY INSURANCE COVERAGE

Dental Coverage: Y N

Insurance Company Name: _____

Address: _____

_____

City State Zip Code

Insurance Co. Phone #: (____) _____

Group Plan, Policy #: _____

Insured's Name: _____

Relation: _____

Insured's Birthdate: _____/_____/_____

Month Day Year

Insured's SS#: _____/_____/_____

Insured's Employer: _____

5 SECONDARY INSURANCE COVERAGE

Dental Coverage ? Y N

Insurance Company Name: _____

Address: _____

_____

City State Zip Code

Insurance Co. Phone #: (____) _____

Group Plan, Policy #: _____

Insured's Name: _____

Relation: _____

Insured's Birthdate: _____/_____/_____

Month Day Year

Insured's SS#: _____/_____/_____

Insured's Employer: _____

6 CONTACT INFORMATION

In the event of an emergency, list the person you would like for us to contact: _____

Relation: _____

Work # _____ Ext. _____

Home #: _____

Cell #: _____

7 DENTAL HISTORY

Do you require antibiotics before dental treatment? Y N

Are you currently in pain? Y N

Do you know or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? Y N

Your current dental health is: Good Fair Poor

Have you ever had a serious/difficult problem associated with any previous dental work? Y N

Brief Explanation:

_____

_____

Do you like your smile? Y N

Would you like whiter teeth? Y N

Fresher Breath? Y N

How many times a week do you a) brush and b) floss?

a) brush_____ b) floss _____

Type of bristles used? Soft / Medium / Hard

Do you snore? Y N

Do you smoke or use tobacco in any other form? Y N

If "Yes", form used: _____

8 MEDICAL HISTORY

Do you have a personal physician? Y N

Physician's Name: _____

Physician's Phone #: (____) _____

Date of last visit: _____

Are you currently under the care of a physician? Y N

Please explain: _____

_____

_____

_____

Your current physical health is: Good Fair Poor

FOR WOMEN

Are you using a prescribed method of birth control? Y N

Are you pregnant? Y N

If "Yes", how many weeks? _____

Are you nursing? Y N

Have you ever had any of the following diseases or medical problems?

Abnormal bleeding	Y N	Liver Disease	Y N	Mitral Valve Prolapse	Y N
Alcohol/Drug Abuse	Y N	Frequent Headaches	Y N	Pacemaker	Y N
Anemia	Y N	Glaucoma	Y N	Psychiatric Problems	Y N
Arthritis	Y N	Hay Fever	Y N	Radiation Treatment	Y N
Artificial Bones/Joints/Valves	Y N	Heart Attack	Y N	Rheumatic / Scarlet Fever	Y N
Asthma	Y N	Heart Murmur	Y N	Seizures	Y N
Blood Transfusion	Y N	Heart Surgery	Y N	Shingles	Y N
Cancer/Chemotherapy	Y N	Hemophilia	Y N	Sickle Cell Disease / Traits	Y N
Colitis	Y N	Hepatitis	Y N	Sinus Problems	Y N
Congenital Heart Defect	Y N	Herpes/Fever Blisters	Y N	Stroke	Y N
Diabetes	Y N	High Blood Pressure	Y N	Thyroid Problems	Y N
Difficulty Breathing	Y N	HIV+ / AIDS	Y N	Tuberculosis (TB)	Y N
Emphysema	Y N	Hospitalized for Any Reason	Y N	Ulcers	Y N
Epilepsy	Y N	Kidney Problems	Y N	Venereal Disease	Y N
Fainting Spells	Y N	Low Blood Pressure	Y N		

Are you allergic to any of the following?

Have you ever taken Fosamax, or any other bisphosphonate? Y N

If "Yes", when did you start and are you taking it now? Y N

Aspirin	Y N	Latex	Y N	Codeine	Y N
Dental Anesthetics	Y N	Penicillin	Y N	Metals	Y N
Erythromycin	Y N	Tetracycline	Y N		
Jewelry	Y N	Sulfa	Y N		

****

Are you taking any prescription medications? Y N **List each prescription and dosage currently taking:**

_____

_____

_____

Are you taking any over-the-counter medication or supplements of any kind? Y N **List each one and dosage currently taking:**

_____

_____

Do you have or have you ever had MRSA (Staph)? Y N **If "Yes", when did you have it and do you have it now?**

_____

If you currently infected, are you being treated by a physician? Y N **Name of Physician:**

_____

****

Please list any serious medical conditions that you have ever had: _____

_____

_____

_____

OFFICE USE ONLY ~ OFFICE USE ONLY ~ OFFICE USE ONLY ~ OFFICE USE ONLY

Dr. Dean Powell

Health History Form

Name of patient here: _____

I verbally reviewed the medical/dental information above with the patient named herein.

Initials _____ **Date:** _____

Doctor's Comments:

_____

_____

_____

MEDICAL HISTORY UPDATE

Date: _____ **Comments:** _____

_____ **Signature:** _____

****

Date: _____ **Comments:** _____

_____ **Signature:** _____

****

Date: _____ **Comments:** _____

_____ **Signature:** _____

****

Date: _____ **Comments:** _____

_____ **Signature:** _____

****

Date: _____ **Comments:** _____

_____ **Signature:** _____