

Welcome

Dr. Kamar Baloul



Adult Health History Form

Today's Date:

1. Your Information

Your Name _____
Last First Mi

Nickname: _____ Male Female

Home # (_____) _____

Cell # (_____) _____

Home Address: _____

City State Zip

Email Address: _____

2. Who may we thank for referring you to our office?

3. Spouse/Partner Information

Name _____ Male Female

Birthdate ____/____/____

Employer _____

Work # (_____) _____ Ext. _____

Home # (_____) _____

Cellular Phone # (_____) _____

SS # _____ DL# _____

4. Hobbies/Sports

5. Person Responsible for Account

Name _____

Relationship _____

Billing Address _____

City State Zip

Home # (_____) _____

Work # (_____) _____

Cellular # (_____) _____

E-mail _____

6. Primary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # (_____) _____

Group # (Plan, Local, or Policy #) _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate ____/____/____

SS#/ Subscriber ID# _____

Policy Owner's Employer _____

7. Secondary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # (_____) _____

Group # (Plan, Local, or Policy #) _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate ____/____/____

Social Security # _____

Policy Owner's Employer _____

8. Dental History

How long since your last visit to the dentist? _____

Previous Dentist's Name _____

Were any x-rays taken at previous dental visits? _____

Have there been any injuries to the teeth, face or mouth? _____

If yes, please explain _____

What is your chief concern? _____

Have you ever had a serious or difficult problem associated with previous dental work? **Yes** **No**

If yes, please explain _____

Have you ever had any pain or tenderness in your jaw/joint? (TMJ/TMD)? **Yes** **No**

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA the CDC, and the ADA.

9. Health History

Do you have any of the following conditions?

- | | |
|--|--|
| Y N Are you pregnant? | Y N Do you take Bisphosphate? |
| Y N Abnormal Bleeding | Y N Disabilities/Special Needs |
| Y N Allergies to any Drugs | Y N Hearing Impairment |
| Y N Any Hospital Stays | Y N Heart Disease/Murmur |
| Y N Any Operations | Y N Hemophilia/Blood Disorders |
| Y N Asthma | Y N Hepatitis |
| Y N Cancer | Y N HIV + / AIDS |
| Y N Congenital Birth Defects | Y N Kidney/Liver Conditions |
| Y N Convulsions/Epilepsy | Y N Rheumatic/Scarlet Fever |
| Y N Pregnancy | Y N Allergies to Latex Product |
| Y N Tuberculosis | Y N Diabetes |
| Y N ADD/ADHD | Y N Autism |
| Y N Do you take aspirin? | |

Please discuss any serious medical conditions you have

Please list all drugs you are currently taking _____

Please list all allergies _____

Child's Physician _____

Phone (_____) _____

Are you currently under the care of a physician? **Yes** **No**

Please describe your current physical health...

Good **Fair** **Poor**

- 10.** I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

Signature of Patient

Date

For Office Use Only

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

Initials _____ Date _____

Doctor's Comments _____
