RSB Dental

New Patient/Health History Form

Name: _____ DOB: ____/_____/_____ Referred by: _____

Address: _____
Street City State Zip

Phone Number: ( ) _____ - _____ SS#: _____-____-_____ Email: _____

Dental Insurance?: Y/N Dental Insurance Name: _____ Policy Holder Name: _____

Policy Holder DOB: __/___/____ Policy Holder SS#: ____-____-_____

Emergency Contact: _____ _____ _____
Name Relation Phone Number

Dental History

Reason for today's dental visit: _____ Date of last dental care: _____

Are any of your teeth sensitive to hot/cold/sweets? _____ Do you grind or clench your teeth? _____

Are you unhappy with the appearance of your smile? _____

Medical History

Please check if you have or have had any of the following:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

Are you currently pregnant? Y/N

Medications

Please list any medications you are taking:

_____

_____

_____

Pharmacy Phone #: (_____)_____-_____

Allergies

- ☐ Penicillin
- ☐ Sulfa
- ☐ Aspirin
- ☐ Codeine
- ☐ Latex
- ☐ Other: _____

Signature: _____ Date: _____