HEALTH HISTORY

South Tampa Dentistry

MR. MRS. MS.
MISS DR. Name _____ Date of Birth _____

Home Phone Number _____ Cell Phone Number _____

Address _____ City _____ State _____ Zip _____

Social Security Number _____ Email _____

Employed by _____ Position _____

Referred by _____

Dental Insurance Company _____ Member ID _____
Are you the policy holder? ☐ yes ☐ no If not, who? _____
Policy Holder DOB _____ Policy Holder SSN _____

Medical History

			Please list any medications
Are you under a physicians care now?	☐ yes	☐ no	_____
Are you allergic to penicillin?	☐ yes	☐ no	_____
Are you allergic to latex?	☐ yes	☐ no	_____
Do you have any artificial joints?	☐ yes	☐ no	_____
Do you have an artificial heart valve?	☐ yes	☐ no	_____
Were you born with a congenital heart defect?	☐ yes	☐ no	
Have you ever had endocarditis?	☐ yes	☐ no	Please list any allergies
Have you ever taken bisphosphonates (ex. fosamax)?	☐ yes	☐ no	_____
Do you use tobacco?	☐ yes	☐ no	_____
Females: Are you pregnant?	☐ yes	☐ no	_____

Do you have any of the following?

☐ AIDS/HIV	☐ Cancer	☐ Excessive Bleeding	☐ Radiation	☐ Stroke
☐ Alzheimers	☐ Chemotherapy	☐ Heart Attack	☐ Osteoporosis	☐ Asthma
☐ Anemia	☐ Chest Pain	☐ Pacemaker	☐ High Blood Pressure	☐ Diabetes
☐ Blood Disease	☐ Epilepsy	☐ Hepatitis	☐ Sinus Troubles	☐ Herpes

Dental History

Date of last dental visit _____ How often do you brush? _____

Are you experiencing discomfort presently? ☐ yes ☐ no How often do you floss? _____

Have you ever had gum treatments? ☐ yes ☐ no Do you wear a nightguard? ☐ yes ☐ no

Do your gums bleed? ☐ yes ☐ no Do you experience dry mouth? ☐ yes ☐ no

Do you experience jaw pain? ☐ yes ☐ no

Signature _____ Date _____