Gibson Dental
GATEWAY TO TOTAL HEALTH & WELLNESS

Health History

Please fill out this form completely, it is important to your dental care. Our goal is to help you reach and maintain good oral health.

ABOUT YOU

Last Name _____ First _____ M.I. ____ Preferred or Nickname _____

☐Male ☐Female Birth Date ____/____/____ Age _____ SS# _____

☐Single ☐Married ☐Partnered

E-mail Address _____

Home Address _____ City _____ State _____ Zip _____

Home # (____) _____ Cell # (____) _____

Work # (____) _____ Best Time To Contact _____

Preferred Method of Contact ☐E-mail ☐Text ☐Phone Call Preferred Number _____

Employer _____

Whom may we thank for referring you? _____

Insurance Policy Holder

Birth Date ____/____/____ SS# _____ Member ID _____

Insurance Company _____ Customer Service Phone # (____) _____

Claims Address _____ City _____ State _____ Zip _____

SPOUSE & EMERGENCY INFORMATION

Spouse's Name _____

Employer _____

Birth Date ____/____/____ Age _____ SS# _____

Home # (____) _____ Cell # (____) _____ Work # (____) _____

E-mail Address _____

In the event of an emergency, whom should we contact?

Name _____ Relationship _____

E-mail Address: _____

Home # (____) _____ Cell # (____) _____ Work # (____) _____

Consent To Photograph The undersigned hereby consents to be photographed while receiving treatment in our office with the understanding that the images from such photography of my treatment may be used for publications in office as well as social media.

Signature _____ Date _____

If signed by other than patient, indicate relationship _____

Privacy Acknowledgement I have received and understand this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the use and disclosures of my protected health information that may be used by this practice, my individual rights and the practice's legal duties with respect to my protected health information. This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. If changes occur, this practice will provide me a revised Notice of Privacy Practices upon request.

Signature _____ Date _____

If signed by other than patient, indicate relationship _____

MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name _____

Phone # (____) _____

Date of last visit _____

Your current physical health is ☐ Good ☐ Fair ☐ Poor

Have you ever taken Fosamax or any other bisphosphonate? ☐ Yes ☐ No

WOMEN
If you are pregnant, we need a consent to treat from your OBGYN.

Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week# _____

Are you nursing? ☐ Yes ☐ No

ARE YOU ALLERGIC TO THE FOLLOWING?

Aspirin	☐ Yes	☐ No	Metals / Plastics	☐ Yes	☐ No
Cinnamon	☐ Yes	☐ No	Penicillin	☐ Yes	☐ No
Codeine	☐ Yes	☐ No	Sulfa	☐ Yes	☐ No
Dental Anesthetics	☐ Yes	☐ No	Tetracycline	☐ Yes	☐ No
Clindamycin	☐ Yes	☐ No	Others _____		
Latex	☐ Yes	☐ No			

Have you ever had any of the following diseases or medical problems? Please check Yes or No.

Cardiovascular

Congenital Heart Devect/MVP	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No
Blood Preassure ☐ High ☐ Low	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No
Date _____		
Stroke	☐ Yes	☐ No
Date _____		
Pace Maker	☐ Yes	☐ No
Date _____		
Artifical Heart Valve	☐ Yes	☐ No
Date _____		

Respiratory

Asthma	☐ Yes	☐ No
COPD	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Tobacco Habit	☐ Yes	☐ No
Seasonal Allergies	☐ Yes	☐ No

Communicable Disease

HIV / AIDS	☐ Yes	☐ No
Hepatitis ☐ A ☐ B ☐ C	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
STD (HPV, Syphilis)	☐ Yes	☐ No

Cancer

Type & Year Diagnosed _____	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No
Radiation Treatment	☐ Yes	☐ No
Remission	☐ Yes	☐ No

Endocrinology

Diabetes	☐ Yes	☐ No
☐ Insulin Dependent		
☐ Non-Insulin Dependent		
Thyroid	☐ Yes	☐ No
☐ High ☐ Low		

Blood Disorders

Sickle Cell Anemia	☐ Yes	☐ No
Abnormal Bleeding	☐ Yes	☐ No
Anemia	☐ Yes	☐ No

Miscellaneous

Arthritis	☐ Yes	☐ No
Artifical Joint(s)	☐ Yes	☐ No
Specify & Date _____		
Joint Replacement	☐ Yes	☐ No
Specify & Date _____		
Osteoporosis	☐ Yes	☐ No
Frequent Headaches	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
Frequent Sinus Infections	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No
Dialysis	☐ Yes	☐ No

Please list ALL medications you are currently taking. _____

Please list any serious medical condition(s) that you have ever had. _____

DENTAL HISTORY

What concerns brought you to the dentist today? _____

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Your current dental health is ☐ Good ☐ Fair ☐ Poor

Do your gums bleed? ☐ Yes ☐ No

Do you like your smile? ☐ Yes ☐ No

How many times a week do you floss? _____

How many times a day do you brush? _____

What type of bristles you use? ☐ Soft ☐ Medium ☐ Hard

How often do you replace your toothbrush? _____

Are your teeth sensitive to heat, cold, or anything else? _____

Have you lost any teeth? ☐ Yes ☐ No If yes, why? _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature _____ Date ____ / ____ / ____