New Patient History Form

Please complete the following information

FALLSTON Dental Care

Patient Name: **Date of Birth:**

Dental History

How long since your last dental/professional cleaning?

Were dental X-rays taken at your last dental appointment? Y N

Have you ever had periodontal treatment? Y N
If yes, what kind of treatment and when?

Have you ever had orthodontic treatment? Y N
If yes, what kind of treatment and when?

Name of your previous dentist:

Previous dental practice phone number:

Medical History

Are you under a physician's care? Y N
If yes, for what condition(s)?

Name of your physician:

Physician's phone number:

Do you require antibiotics from your cardiologist, orthopedic surgeon or any other physician prior to dental treatment? Y N
If yes, please explain:

Do You Have Any of the Following?

Acid Reflux Y N

AIDS or HIV Positive Y N

Alcohol/Narcotic Addiction Y N

Alzheimer's Y N

Anxiety Y N

Artificial Joint Replacements (Please Specify) Y N

Artificial Heart Valve Y N

Asthma Y N

Auto Immune Disorders Y N
(Lupus, Fibromyalgia, Chronic Fatigue, Sjogren's Syndrome)

Blood Disorders (Anemia, Leukemia, Excess Bleeding) Y N

Cancer Y N

Dementia Y N

Diabetes Y N

Eating Disorders (Anorexia, Bulimia, Weight Loss Surgery) Y N

Epilepsy or Seizure Disorders Y N

Hearing Loss/Hearing Aids Y N

Heart Murmur, Stents Y N

Hepatitis Y N

High Blood Pressure Y N

High Cholesterol Y N

Inflammatory Diseases (Arthritis or Rheumatoid) Y N

Latex Allergy Y N

Low Blood Pressure Y N

Organ Transplant Y N

Osteoporosis Y N

Pacemaker Y N

Psychological or Behavior Disorders Y N

Sleep Apnea Y N

STD/ Venereal Disease (Past or Present) Y N

Stomach, Kidney, or Liver Problems Y N

Thyroid Problems Y N

Tuberculosis (Past or Present) Y N

Vertigo or Inner Ear Problems Y N

For Women Only:

Are you taking birth control pills? Y N

Are you pregnant? Y N

Are you nursing/breastfeeding? Y N

Continued on the next page...

New Patient History Form

Please complete the following information

FALLSTON Dental Care

Medical Questions:

Are you taking any medications? Y N
If yes, please list:

Are you allergic to any medications? Y N
If yes, please list:

Do you routinely take vitamins or herbal substances? Y N
If yes, please list:

Have you had or are currently having radiation/chemo treatment? Y N
Date of last treatment:

Have you had or do you test positive for hepatitis? Y N
If yes, when:

Do you now use or have you ever used tobacco products or smokeless tobacco products? Y N
If yes, what type, how often:

Do you have any dental anxiety or fear? Y N
Please explain:

Do you have any mental, learning, or physical condition we should know about? Y N
Please explain:

Do you require PRE-MEDICATION/ANTIBIOTICS from your cardiologist, orthopedic surgeon or any other physician prior to dental treatment? Y N
If yes, please explain for what:

Are you taking any blood thinners (aspirin, Plavix, Coumadin) etc. Y N
What:

Had artificial joint replacement such as hip or knee, etc. and when:

Do you have or ever had Osteoporosis? Y N

Have you ever taken Bisphosphonates (Fosomax, Zometa, Reclast or Boniva or IV Bisphosphonates)? Y N
What:

When:

Have you even taken Bisphosphonates for Osteoporosis? Y N

What would you like to change about your smile?

Is there anything not mentioned above that you feel we should know?

Please note our posted Personal Health Information Privacy Policy. In accordance with HIPPA regulations, we will use your personal health information for treatment, payment for services, and/or healthcare operations. List who in your family we may discuss this information with:

Name:
Relationship:
Date:

Name:
Relationship:
Date:

By completing this form, you certify that all information provided to Fallston Dental Care is true, correct, and complete and agree to promptly inform Fallston Dental Care of any changes in any information (including regarding any dependent). Fallston Dental Care is authorized to use and disclose to any insurance, billing, management, or processing company, agency or organization any health care information/medical records relating to the undersigned or any dependent to obtain payment for services, determine insurance benefits or otherwise as required by law. Fallston Dental Care is authorized to contact the undersigned at any telephone number provided above (unless otherwise revoked in writing) to discuss this form and any billing, treatment, or other matter related to any dental treatment (including for any dependent).

Guarantor (if minor) Signature:
Print Name:
Date:

By completing this form, you certify that all information provided to Fallston Dental Care is true, correct, and complete and agree to promptly inform Fallston Dental Care of any changes in any information (including regarding any dependent). Fallston Dental Care is authorized to use and disclose to any insurance, billing, management, or processing company, agency or organization any health care information/medical records relating to the patient or any dependent to obtain payment for services, determine insurance benefits or otherwise as required by law. Fallston Dental Care is authorized to contact the patient at any telephone number provided above (unless otherwise revoked in writing) to discuss this form and any billing, treatment, or other matter related to any dental treatment (including for any dependent). Please note our Personal Health Information Privacy Policy posted in the office.