Loveland Dental Hygiene
Health History Form

Email: Today's Date:

As required by law, my office adheres to written policies and procedure to protect the privacy of information about you that I create, receive or maintain. Your answers are for my records only and will be kept confidential subject to applicable laws. Please not that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: Last First MI
Preferred Phone: Include area code ( )
Other Phone: include area code ( )

Address: Mailing address
City:
State:
Zip:

Date of Birth: Sex: Preferred Name:

Emergency Contact: Relationship: Phone number: include are code ( )

If you are completing this form for another person, what is your relationship to that person?
Your name: Your Relationship

Dental Information
for the following questions, please mark (x) your responses to the following questions

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Do you wear a night guard when you sleep?	☐	☐	☐
Are you currently experiencing dental pain or discomfort?	☐	☐	☐
What is the reason for your dental visit today?	☐	☐	☐

How do you feel about your smile?__________________________

	Yes	No	DK
Do you have earaches or neck pain?	☐	☐	☐
Do you have any clicking, popping or discomfort in your jaw?	☐	☐	☐
Do you clench or grind your teeth?	☐	☐	☐
Do you have any sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in sports requiring the use of a mouth guard?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last exam:__________________________
What was done at that time?__________________________
Date of last dental x-rays:__________________________
Do you brush, floss, water pick or other? ____________________

Medical Information
Please mark (x) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Are you under the care of a physician?	☐	☐	☐

Physician Name: __________________________
Physician Phone Number?
____
Address/ City/ State/ Zip? __________________________
____
____

	Yes	No	DK
Are you in good health?	☐	☐	☐
Has there been any change in your general health in the past year?	☐	☐	☐

If yes, what condition is being treated?
____
____
____
Date of last physical exam?

	Yes	No	DK
Have you had a serious illness, operating or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or condition?__________________________
____

	Yes	No	DK
Are you taking or have you recently taken any prescriptions or over the counter medications?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations or dietary supplements:
____
____
____
____
____

Medical Information *please mark (X) your response to indicate if you have or have not had any of the following diseases or problems*

Check DK if you don't know the answer to the question) **Yes No DK**	Yes No DK		Yes No DK
Do you wear contact lenses?	☐ ☐ ☐	Do you use tobacco (smoking, snuff, chew, bidis)?	☐ ☐ ☐
Joint Replacement		If so how interested are you in stopping? Circle one: VERY /SOMEWHAT/ NOT INTERESTED	
Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐ ☐ ☐	Do you drink alcoholic beverages?	☐ ☐ ☐
If yes, do you take antibiotics before dental treatment?	☐ ☐ ☐	If yes, how much alcohol did you drink in the last 24 hours?____	
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for Osteoporosis or Paget's disease?	☐ ☐ ☐	If yes, how much do you typically drink in a week?____	
Since 2001, were you treated or are you presently scheduled to begin Treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) For bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma, or metastatic cancer?	☐ ☐ ☐	**Women Only:** Are you pregnant? Number of weeks______________________	☐ ☐ ☐
Date treatment began: ____		Nursing?	☐ ☐ ☐
Do you use controlled substances?	☐ ☐ ☐	Taking birth control or hormone replacement?	☐ ☐ ☐

Allergies: Are you allergic to or have you had a reaction to:

To all yes responses, specify type or reaction	Yes, No, DK		
Local Anesthetics___________________________________	☐ ☐ ☐	Metals______________________________	☐ ☐ ☐
Penicillin or other antibiotics__________________________	☐ ☐ ☐	Latex (rubber)_________________________	☐ ☐ ☐
Aspirin____	☐ ☐ ☐	Iodine________________________________	☐ ☐ ☐
Barbiturates, sedatives or sleeping pills_________________	☐ ☐ ☐	Hay fever/ seasonal____________________	☐ ☐ ☐
Sulfa drugs____	☐ ☐ ☐	Animals______________________________	☐ ☐ ☐
Codeine of other narcotics___________________________	☐ ☐ ☐	Food________________________________	☐ ☐ ☐
	☐ ☐ ☐	Other________________________________	☐ ☐ ☐

	Yes No DK
Artificial (prosthetic) heart valve...............................	☐ ☐ ☐
Previous infective endocarditis....................................	☐ ☐ ☐
Damaged valves in transplanted heart.......................	☐ ☐ ☐
Congenital heart disease (CHD).................................	☐ ☐ ☐
Unrepaired cyanotic CHD	☐ ☐ ☐
Repaired completely in the last 6 months	☐ ☐ ☐
Repaired CHD with residual defects	☐ ☐ ☐

Please mark (x) your response to indicate if you have or have not had any of the following diseases or problems.

	Y N DK		Y N DK
Cardiovascular Disease..........................	☐ ☐ ☐	Mitral Valve Prolapse	☐ ☐ ☐
Angina..........................	☐ ☐ ☐	Pacemaker.................	☐ ☐ ☐
Arteriosclerosis............	☐ ☐ ☐	Rheumatic Fever........	☐ ☐ ☐
Congestive heart failure............................	☐ ☐ ☐	Rheumatic Heart Disease..........................	☐ ☐ ☐
Damaged Heart Valves	☐ ☐ ☐	Abnormal Bleeding...	☐ ☐ ☐
Heart Attack.................	☐ ☐ ☐	Anemia.......................	☐ ☐ ☐
Heart Murmur..............	☐ ☐ ☐	Blood Transfusion, if yes date___________	☐ ☐ ☐
Low Blood Pressure.....	☐ ☐ ☐	Hemophilia................	☐ ☐ ☐
High Blood Pressure....	☐ ☐ ☐	AIDS or HIV infection	☐ ☐ ☐
Other Congenital Heart Disease...............	☐ ☐ ☐	Arthritis......................	☐ ☐ ☐

	Y N DK		Y N DK
Autoimmune disease......	☐ ☐ ☐	Glaucoma........................	☐ ☐ ☐
Rheumatoid arthritis......	☐ ☐ ☐	Epilepsy..........................	☐ ☐ ☐
Systemic lupus erythematosus.................	☐ ☐ ☐	Fainting spells or Seizures..........................	☐ ☐ ☐
Asthma.............................	☐ ☐ ☐	Sleep disorder................	☐ ☐ ☐
Bronchitis.........................	☐ ☐ ☐	Do you snore?..............	☐ ☐ ☐
Emphysema......................	☐ ☐ ☐	Kidney Problems...........	☐ ☐ ☐
Sinus trouble....................	☐ ☐ ☐	Night Sweats.................	☐ ☐ ☐
Tuberculosis.....................	☐ ☐ ☐	Osteoporosis.................	☐ ☐ ☐
Cancer/chemotherapy/ Radiation..........................	☐ ☐ ☐	Sexually Transmitted Disease...........................	☐ ☐ ☐
Chest Pain upon exertion	☐ ☐ ☐	Hepatitis, jaundice or liver disease....................	☐ ☐ ☐
Chronic Pain.....................	☐ ☐ ☐	Neurological disorders, Specify_______________	☐ ☐ ☐
Diabetes Type I or II.........	☐ ☐ ☐		
Eating disorder................	☐ ☐ ☐	Mental health disorders, Specify_______________	☐ ☐ ☐
Malnutrition......................	☐ ☐ ☐		
Gastrointestinal disease...	☐ ☐ ☐	Recurrent Infections, type of infection: _______________	☐ ☐ ☐
G.E. Reflux/ Persistent heartburn...........................	☐ ☐ ☐		
Ulcers.................................	☐ ☐ ☐	Persistent Swollen glands in neck................	☐ ☐ ☐
Thyroid Problems..............	☐ ☐ ☐		
Stroke.................................	☐ ☐ ☐	Severe Headaches/ migraines........................	☐ ☐ ☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?.................................	☐ ☐ ☐
Name of physician or dentist making recommendation. Phone: ( )	
Do you have any disease, condition or problem not listed above that you think I should know about?... Please Explain:	☐ ☐ ☐

Consent for Services (Please initial each line)

_____ I understand that I am being seen by a licensed Colorado Dental Hygienist. I have been informed that the ADA recommends a dentist exam every 6 months.

____I understand that Loveland Dental Hygiene will have my radiographs viewed and evaluated by a licensed dentist.

____I understand that communication will be done via email and that it may not be encrypted. (Appointment reminders, x-rays, treatment notes, etc.) ***Things like social security number and account information will not be shared, unless with an insurance company, which is encrypted.***

___ Payment is solely the responsibility of the patient or responsible party. We will gladly bill insurance as a service to you, but any nonpayment or partial payment is then the patient's responsibility. Nonpayment may result in turning over your account to a collections agency.

___If insurance is filed: I authorize Loveland Dental Hygiene, LLC to accept all assignment of benefits. If you do not wish to assign your benefits to Loveland Dental Hygiene, LLC your payment will be due at time of service and insurance benefits will be sent directly to you.

I have read the above conditions of treatment and payment and I agree to their content.

____ Date: _____________ Relationship to Patient: _______________
Signature of patient, parent or guardian

Patient's Primary Dental Insurance Information

Subscriber's Name	Subscriber's ID	Subscriber's DOB	Group Number	Insurance Company
Employer	Address of Employer	Relationship to Patient		

I hereby authorize direct payment of the dental benefits otherwise payable to me, directly to Loveland Dental Hygiene, LLC.

____ _____________________________________

Signature Date