PATIENT ID#: _____

ENLOW & VANCE DENTAL PARTNERS

HEALTH HISTORY INFORMATION

Patient Information:

Name _____ Home Phone _____ Work Phone _____

Street Address _____ Cell Phone _____

City _____ State _____ Zip _____ Birth Date _____ SS# _____

Employer Name _____ Marital Status _____ Spouse's Name _____

How did you hear about us? : _____ Email _____ Emergency Contact _____

Insurance Information:

Policy Holder's Employer Name _____ Group # _____

Insurance Company Name/Address/Phone # _____ _____

IF INSURED IS DIFFERENT THAN THE PATIENT, FILL IN THE FOLLOWING:

Name/Relationship to patient _____ Birth Date _____ SS# _____

MEDICAL HEALTH HISTORY

Name of Physician _____ Last Complete Physical _____

Are you (___currently taking) or (___ taken in the past) Bisphosphonate Medications: ___Yes ___ No.

If Yes, please circle which one: Fosamax, Actonel, Boniva, Zometa, Aredia, Other _____

If you answered "taken in the past", how long ago did you take the medicine and for how long did you take it? _____

Are you taking any other medications now? ___Yes ___No If yes, for what purpose? _____

List Medications: _____

Please mark if you are allergic to any of the following: ___Aspirin, ___Penicillin, ___ Codeine, ___Acrylic, ___Metal, ___ Latex, ___ Local Anesthetics. List any others: _____

If marked, please describe allergic reaction to drug: _____

Do you use tobacco? ___Yes ___No

Please check if any of the following apply:

__AIDS/HIV Positive	__Heart Pacemaker	__Cough	__Prolonged Bleeding
__Hepatitis A	__Angina/Chest Pains	__Sinus Problems	__Hives or Rash
__Hepatitis B or C	__Artificial Heart Valve	__Lung Disease	__Psychiatric Care
__Liver Disease	__Heart Murmur	__Tuberculosis	__Epilepsy or Seizures
__Jaundice	__Heart Trouble/disease	__Emphysema	__Convulsions
__Alzheimer's Disease	__Mitral Valve Prolapse	__Easily winded	__Sjogren's Syndrome
__Arthritis	__Heart Attack/Failure	__Breathing Problem	__Steroid/Cortisone Medication
__Rheumatism	__High Blood Pressure	__Glaucoma	__Birth Control Pills
__Gout/Swelling of Limbs	__Low Blood Pressure	__Kidney Problems	__Drug addiction
__Artificial Joints/Limbs	__Excessive Thirst	__Renal Dialysis	__Fainting Spells/Dizziness
__Leukemia	__Diabetes	__Stomach/Intestinal Disease	__Frequent Cough
__Tumors or Growths	__Hypoglycemia	__Ulcers	__Frequent Diarrhea
__Cancer, Please specify: _____	__Rheumatic Fever	__Tonsillitis	__Facial, Jaw, or Neck pain
__Chemotherapy	__Scarlet Fever	__Blood Disease	__Frequent Headaches
__Radiation Therapy	__Stroke	__Blood Transfusion	__Earaches
__Cold Sores/Fever Blisters	__Thyroid Disease	__Bruise Easily	__Ear Stuffiness
__Congenital Heart Disorder	__Recent Weight Loss	__Anemia	__Ringing in Ears
__ Irregular Heartbeat	__Asthma	__Hemophilia	__Other_____

Authorization:

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to obtain such information from other health care providers or agencies as needed, who may release such information to you. I understand it is my responsibility to inform the doctor of any changes in my health or medications. I authorize the release of any information required for referring dental professionals or for completion of insurance claims. I further authorize that payment go directly to Enlow & Vance Dental Partners, PA. A copy of this authorization may be used in place of the original. I also authorize the use of photos and x-rays of my treatment, both before and after, for promotional and training purposes. I accept full responsibility for fees incurred for dental treatment rendered to me by Enlow & Vance Dental Partners, PA.

Date: _____ Patient/Guardian Signature: _____