

Are you subject to fainting spells? Yes No

Do you have excessive urination and/or thirst? Yes No

Reason for visit: _____

When was your last dental visit? _____

How do you feel about the appearance of your teeth: _____

Have you ever been interested in cosmetically changing your smile? Yes No

Are you interested in teeth whitening? Yes No

Have you ever had any serious problem associated with previous dental treatment Yes No

If so, explain: _____

Do your gums bleed while brushing? Yes No

Do you avoid brushing any part of your mouth because of pain? Yes No

If yes, what part? _____

Do you chew on only one side of your mouth? Yes No

Do your gums feel tender or swollen? Yes No

Do you clench or grind your jaws while sleeping or during the day? Yes No

Do you have jaw pain or TMJ problems? Yes No

Do you wear dentures? Yes No

If yes, when were they made? _____

Is there anything concerning your past or present medical or dental history which you feel the doctor should know about? Yes No

If yes, please describe: _____

I certify that I have read, understood and personally reviewed the above questions and answers and that to the best of my knowledge that they are true and correct. If I ever have any change in my health, or medications change, I will inform the Doctor of Dentistry on the next appointment without fail.

The undersigned hereby authorizes this office to release all records to insurance companies and any specialists for continuing treatment.

I understand that the Dentists practicing in this office are independent practitioners and are not controlled or directed by Dental Health Services or any professional corporation.

Date

Patient Signature
(Parent's signature if patient is a minor)

HEALTH HISTORY UPDATE:

I have reviewed my previous health history form and as of this date there is no change.

Date Signature

Date Signature

Date Signature

Date Signature

SUMMARY (For office use only)

Doctor's Signature

PATIENT HEALTH RECORD

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Spouse or Legal Guardian _____
Last Name First Name Initial

Address _____ Home Phone _____

City _____ State _____ Zip _____ Cell Phone _____

E-mail Address: _____

Sex M F Age _____ Birthdate _____ Height _____ Weight _____

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

In case of emergency notify: _____ Home Phone _____ Work Phone _____ Cell Phone _____

If you are completing this form for a patient:

What is your name? _____

What is your relationship to the patient? _____

MEDICAL HEALTH

General Health (please check) EXCELLENT GOOD FAIR POOR

Name and address of physician _____

Last visit to physician _____ For what purpose _____

Are you taking any medication now: Yes No For what purpose _____

List any medication(s) you are now taking: _____

Have you ever had any serious illness/operation or hospitalization? Yes No

Please describe _____

Have you had, or do you have at present:

Heart disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Rheumatic fever	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Abnormal blood pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Ulcers	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Tuberculosis or lung disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Epilepsy	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Anemia	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Congenital heart lesions	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Joint replacement	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Surgery with pins or plate	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heart murmur	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heart valve problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Jaundice	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Chemical dependency	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Angina	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heart pacemaker	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Asthma or hay fever	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Sinus trouble	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cancer or Cancer treatment	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hepatitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Arthritis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Stroke	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Glaucoma	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Herpes	Yes <input type="checkbox"/>	No <input type="checkbox"/>
AIDS	Yes <input type="checkbox"/>	No <input type="checkbox"/>
HIV positive	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Do you smoke or use tobacco products? Yes No If so, how often _____

Have you been hospitalized in the last 5 years? Yes No

Have you ever been treated with radiation therapy? Yes No

Have you or are you currently being treated for: Osteoporosis, osteosarcoma or post menopausal bone loss? Yes No

Have you or are you currently taking a Fosamax type drug? Yes No

Are you allergic to: Penicillin Codeine Local injected anesthetics Other medications _____ None
Material Allergies: Latex Metal Other _____ None

Are you subject to prolonged bleeding? Yes No

Women: Are you pregnant? Y N Nursing? Y N Taking birth control pills? Y N
(over)

GOFF DENTAL

PHILLIP J. GOFF D.D.S.,PA

WE ALWAYS ENJOY SEEING NEW FACES IN OUR OFFICE. WE'D LIKE TO WELCOME YOU TO OUR PRACTICE AND THANK YOU FOR SELECTING US FOR YOUR DENTAL CARE. WE LOOK FORWARD TO SEEING YOU AGAIN. PLEASE FEEL FREE TO ASK ANY OF OUR STAFF ABOUT THE OPERATION OF OUR OFFICE. THEY WILL BE MORE THAN HAPPY TO ANSWER ANY OF YOUR QUESTIONS.

FINANCIAL POLICY

OUR OFFICE OPERATES ON A FEE FOR SERVICE BASIS. THAT IS, PAYMENT IS REQUIRED AT THE TIME SERVICE IS RENDERED. WE DO NOT SEND STATEMENTS OR MONTHLY BILLS. WE DO THIS IN AN EFFORT TO KEEP OUR COSTS, AND THEREFORE OUR FEES, AS LOW AS POSSIBLE.

IF YOU HAVE DENTAL INSURANCE, PLEASE ASK THE RECEPTIONIST ABOUT HOW WE HANDLE INSURANCE. YOU ARE ALWAYS RESPONSIBLE FOR ANY UNPAID BALANCE ON YOUR ACCOUNT(IF ANY) AFTER YOUR INSURANCE COMPANY HAS PAID.

DO YOU HAVE ANY TYPE OF DENTAL INSURANCE? YES ___ NO ___

IF YES,

PLEASE PROVIDE THE PROPER INFORMATION BELOW:

NAME OF INSURANCE: _____

NAME OF INSURED: _____

INSURED'S SOCIAL SECURITY NUMBER: _____

NAME OF PATIENT: _____

PATIENT'S SIGNATURE: _____