DR ERIC GOLDBERG HEALTH HISTORY FORM

It is our goal to provide you with high quality care, assuring you long-term health and comfort.

ABOUT YOU

Today's Date:_____ E-mail Address:_____

NAME:_____
LAST FIRST MI MR MRS MS DR

I prefer to be called:_____ Male Female Other

Birth date:___/___/___ AGE:_____ SS#_____

Home Address:_____
APT / CONDO #

_____
CITY STATE ZIP

Single Married Divorced Widowed Separated Partnered

HM # (___)_____ Pager / Other #: _____

WK# (___)_____Ext:____ DL#: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & When are best times to reach you? _____

Whom may we thank for referring you? _____

Other family members see by us: _____

Previous / Present Dentist: _____
(please circle)

Last Visit Date: _____

DENTAL INSURANCE

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (___)_____

Group # (Plan, Local or Policy #) _____

Insured's Name: _____ Relation:_____

Insured's Birth date:___/___/___Insured's SS#_____

Insured's Employer: _____

Employer's Address:_____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (___)_____

Group # (Plan, Local or Policy #) _____

Insured's Name: _____ Relation:_____

Insured's Birth date:___/___/___Insured's SS#_____

Insured's Employer: _____

Employer's Address:_____

SPOUSE INFORMATION

HIS / HER Name: _____

Employer: _____

Wk #: _____ Ext: _____ SS #: _____

Birth date: ___/___/___ DL #: _____

In the event of an emergency, is there someone who lives near you that we should contact?

HIS / HER Name:_____ Relation:_____

Wk #: (___)_____ Hm #: (___)_____

Person Responsible for Account:_____

Work #: (___)_____Ext:____ Home #:(___)_____

Billing Address: _____

Relation: _____ SS #:_____

Employer: _____ DL#:_____

MEDICAL HISTORY

Do you have a personal physician? Yes No

Physician's Name: _____

Wk #: (___)_____ Date of Last visit:_____

Medical History (continued)

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes No

Please Explain:_____

Are you taking any prescription / over-the-counter drugs? Yes No

Please list each one:_____

Do you smoke or use tobacco in any other form? Yes No

For Women: Are you taking birth control pills? Yes No

Are you pregnant? Yes No Week #:_____

Are you nursing? Yes No

Have you ever had any of the following disease or medical problems? (Please circle option that applies)

Y N	Anemia / Radiation Treatment	Y N	Hemophilia / Abnormal Bleeding
Y N	Artificial Bones / Joints/ Valves	Y N	Hepatitis
Y N	Arthritis	Y N	High / Low Blood Pressure
Y N	Asthma	Y N	HIV+ / AIDS
Y N	Blood Transfusion	Y N	Hospitalized for Any Reason
Y N	Cancer / Chemotherapy	Y N	Kidney Problems
Y N	Congenital Heart Defect	Y N	Mitral Valve Prolapse
Y N	Diabetes	Y N	Psychiatric Problems
Y N	Difficulty Breathing	Y N	Rheumatic / Scarlet Fever
Y N	Drug / Alcohol Abuse	Y N	Severe / Frequent Headaches
Y N	Emphysema / Glaucoma	Y N	Shingles
Y N	Epilepsy /Seizures / Fainting Spells	Y N	Sickle Cell Disease / Traits
Y N	Fever Blisters / Herpes	Y N	Sinus Problems
Y N	Heart Attack / Stroke	Y N	Tuberculosis (TB)
Y N	Heart Murmur	Y N	Ulcers / Colitis
Y N	Heart Surgery / Pacemaker	Y N	Venereal Disease

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

_____

Are you allergic to any of the following?

Y N	Aspirin	Y N	Erythromycin	Y N	Penicillin
Y N	Codeine	Y N	Jewelry / Metals	Y N	Tetracycline
Y N	Dental Anesthetics	Y N	Latex	Y N	Other

Please list any other drugs / material that you are allergic to :_____

_____

Dental History

Why have you come 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 you like your smile? Yes No

Do your gums ever bleed? Yes No

How many times a week do you floss?____ a day do you brush?____

Type of bristles? Hard Medium Soft

Have you ever taken Phen-Fen? Yes No
(also known as Redux or Pondimin)

If so when? _____

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. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____
Signature Date

Payment is due in full at the time of treatment unless prior arrangements have been approved.

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.

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I verbally reviewed the medical / dental information above with the patient named herein. Initials_____Date:_____

Doctor's Comments:_____

MEDICAL HISTORY UPDATE

1. Date:_____ Comments:_____ Signature:_____
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