

# 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

Birth date: \_\_\_/\_\_\_/\_\_\_ AGE: \_\_\_\_\_ SS# \_\_\_\_\_

Home Address: \_\_\_\_\_  
APT / CONDO # \_\_\_\_\_

CITY STATE ZIP

Single Married Divorced Widowed Separated

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: _____ |
| 1. Date: _____ | Comments: _____ | Signature: _____ |
| 1. Date: _____ | Comments: _____ | Signature: _____ |