ZION FAMILY DENTISTRY

Health History

2671 Sheridan Rd
Zion, IL 60099
847-872-4782
www.zionfamilydentistry.com

Patient Information

Date_____

Name_____ Date of Birth_____ Age_____
First M.I. Last

Home Address_____ City _____ Zip_____

Occupation_____ Married ❒ yes ❒ no Phone #_____Cell #_____

How did you hear about us _____ Email _____

Who is responsible for this account: Name _____Phone # _____

Address _____ Occupation _____ Employer _____

Reason for visit: ❒ Complete Exam ❒ Emergency ❒ 6 Month Checkup ❒ Other _____

Oral Health Information

Last dental exam & x-rays _____

Name of previous Dentist _____

Are you having any dental pain ❒ yes ❒ no

Are your teeth sensitive to hot/cold/sweet/biting ❒ yes ❒ no

Do your gums bleed when brushing/flossing ❒ yes ❒ no

Do you want to replace any missing teeth ❒ yes ❒ no

Are you unhappy with your smile ❒ yes ❒ no

Are you interested in whitening your teeth ❒ yes ❒ no

Do you clench or grind your teeth ❒ yes ❒ no

Do you have TMJ problems/popping ❒ yes ❒ no

Medical Information

Name of Physician _____

Ever had serious injury/illness or surgery ❒ yes ❒ no

Describe _____

Ever had excessive bleeding after extraction ❒ yes ❒ no

Are you allergic to any medications ❒ yes ❒ no

Please list _____

Do you Smoke ❒ yes ❒ no If yes, how much _____

WOMEN: Are you or could you be pregnant ❒ yes ❒ no

If yes, how far along _____

Are you breastfeeding ❒ yes ❒ no

Are you taking any medications (including contraceptives)? ❒ yes ❒ no Please list:

_____

Do you have, or have you ever had, any of the following:

Joint replacement	❒ yes ❒ no	Diabetes	❒ yes ❒ no	Blood disorder	❒ yes ❒ no
Osteoporosis	❒ yes ❒ no	Cancer	❒ yes ❒ no	Headaches/migraines	❒ yes ❒ no
High Blood Pressure	❒ yes ❒ no	Fainting or dizziness	❒ yes ❒ no	Thyroid condition	❒ yes ❒ no
Heart Disease	❒ yes ❒ no	Epilepsy/Seizures	❒ yes ❒ no	Kidney disease	❒ yes ❒ no
Congenital heart defect	❒ yes ❒ no	Excessive bleeding	❒ yes ❒ no	Pacemaker	❒ yes ❒ no
Dental pre-medication	❒ yes ❒ no	Hepatitis/Liver disorder	❒ yes ❒ no	Radiation therapy	❒ yes ❒ no
Stroke	❒ yes ❒ no	Autoimmune disorder	❒ yes ❒ no	Digestive problems	❒ yes ❒ no
Asthma	❒ yes ❒ no	Tuberculosis	❒ yes ❒ no	Nervous Disorder	❒ yes ❒ no
Respiratory disorder	❒ yes ❒ no	HIV/AIDS	❒ yes ❒ no	Difficulty breathing	❒ yes ❒ no

Do you have anything else we have not asked? _____

Consent for Treatment

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding medical condition. I shall inform the dentist and staff of any changes at the next appointment without fail. Payment for all treatment and services rendered are my responsibility.

X_____ Date_____ Relation_____
Patient or legal Guardian Relationship to minor

HIPPA Acknowledgement

By signing below I acknowledge that I was offered a copy of this office's state and federal Notice of Privacy Practices and had full opportunity to consider the contents of the consent. I understand that by signing, I am confirming my writtien permission for the disclosure of my protected health information, as described in the forms.

X_____ Date_____ Relation_____
Patient or legal Guardian Relationship to minor

 Last updated 03/06/2017