HEALTH HISTORY

Riverview Dentistry

MR. MRS. MS.
MISS DR. Name _____ Date of Birth_____

Home Phone Number_____Cell Phone Number_____

Address _____City _____State_____Zip_____

Social Security Number _____ Email_____

Employed by _____ Position_____

Referred by_____

Dental Insurance Company _____ Member ID _____
Are you the policy holder? ☐ yes ☐ no If not, who? _____
Policy Holder DOB_____Policy Holder SSN _____

Medical History

Are you under a physicians care now?	☐ yes	☐ no
Are you allergic to penicillin?	☐ yes	☐ no
Are you allergic to latex?	☐ yes	☐ no
Do you have any artificial joints?	☐ yes	☐ no
Do you have an artificial heart valve?	☐ yes	☐ no
Were you born with a congenital heart defect?	☐ yes	☐ no
Have you ever had endocarditis?	☐ yes	☐ no
Have you ever taken bisphosphonates (ex. fosamax)?	☐ yes	☐ no
Do you use tobacco?	☐ yes	☐ no
Females: Are you pregnant?	☐ yes	☐ no

Please list any medications

_____
_____
_____
_____
_____
_____

Please list any allergies

_____
_____
_____
_____

Do you have any of the following?

☐ AIDS/HIV	☐ Cancer	☐ Excessive Bleeding	☐ Radiation	☐ Stroke
☐ Alzheimers	☐ Chemotherapy	☐ Heart Attack	☐ Osteoporosis	☐ Asthma
☐ Anemia	☐ Chest Pain	☐ Pacemaker	☐ High Blood Pressure	☐ Diabetes
☐ Blood Disease	☐ Epilepsy	☐ Hepatitis	☐ Sinus Troubles	☐ Herpes

Dental History

Date of last dental visit _____ How often do you brush?_____

Are you experiencing discomfort presently? ☐ yes ☐ no How often do you floss?_____

Have you ever had gum treatments? ☐ yes ☐ no Do you wear a nightguard? ☐ yes ☐ no

Do your gums bleed? ☐ yes ☐ no Do you experience dry mouth? ☐ yes ☐ no

Do you experience jaw pain? ☐ yes ☐ no

Signature_____ Date_____