H. TALBOTT TEBAY, D.D.S.

Jacqueline Stump, D.D.S. ~ Matt Stump, D.D.S.

PERSONAL HEALTH HISTORY

This information is strictly confidential and will not be released without your written authorization.

Patient's Name: ____
Last First Middle Preferred

Address: ____
Number and Street

____
City State Zip Code

Telephone: (____)____________________ (____) ____________________(____)____________________
Home Work Cell

Email address: ______________________________**Social Security:**______________________________

Employer: ____

Date of Birth: ____________________ **Sex:** _______ **Height:** _______ **Weight:** ________ **Married** _______ **Single** _______

Closest Relative: ____________________________ **Relationship:** ___________________ **Telephone:** (______)______________________

Individual Insured by Primary Dental Insurance:____
(If different from self)

Primary Dental Insurance: ______________________________ **ID#:** ____________________**Group #:** ______________

Date of Birth: ____________________**Social Security:** ____________________**Employer:** ______________________________
(*If different from self)*

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Individual Insured by Secondary Dental Insurance: ____

Secondary Dental Insurance: ______________________________ **ID#:**____________________ **Group #:** ______________

Date of Birth: ___________________**Social Security:** ____________________**Employer:** ______________________________
(*If different from self)*

Please answer the following to the best of your ability and if any questionable areas occur, MARK YES. This information helps us in the proper use of medications, anesthetics, treatment of hard and soft tissues, and safety precautions for infectious diseases.

1. **List any health/physical/emotional/mental health/neurological problems:** ______________________________
   (example: depression, sleep disorder, autoimmune/alloimmune, cerebral palsy, mental retardation, ADD/ADHD, etc...)
2. **My last physical examination was on:** ________________________
3. **List any drugs or medications you are taking:**
   ____
4. **Have you ever reacted adversely to:**

	(YES)	(NO)
A. **Local Anesthetics/ IV Dyes**	_____	_____
B. **Penicillin/Keflex/Tetracycline/Other Antibiotics**	_____	_____
C. **Sulfa Drugs** *(example: Bactrim, Celebrex, Lasix, Glipizide, Erythromycin, Imitrex, Amaryl)*	_____	_____
D. **Barbiturates, Sedative, or Sleeping Pills**	_____	_____
E. **Aspirin/Ibuprofen**	_____	_____
F. **Codeine/Darvocet or other Narcotics**	_____	_____
G. **Latex, Metals, Plastics**	_____	_____
H. **Any other Medications**	_____	_____

   If YES, what kind of reactions? ____
   (example: rash, itching, shortness of breath, wheezing, anaphylaxis, anaphylactic shock, dizziness, stomach pain, rapid heart beat, hives, hallucinations, etc…)

5. **List any serious problems you have had with previous dental treatment.**______________________________
   ____
6. **Are you allergic to anything?** ____

(ADDITIONAL QUESTIONS ON REVERSE SIDE)
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(YES) (NO)

7. Do you bleed a great deal after tooth extraction or cut, take aspirin or blood thinners? _____ _____
(example: Aspirin, Coumadin(Warfarin), Plavix, Lovenox, Aggrenox, Heparin, etc…)
If you checked yes, which medications? _____

8. Have you ever had any of the following?
(Check off if the answer is YES)

_____ **Anemia**	_____ **Eating Disorder**	_____ **High Blood Pressure**	_____ **Radiation**
_____ **Arthritis**	_____ **Epilepsy (Seizures)**	_____ **Irregular Heartbeat**	_____ **Recent Weight Loss**
_____ **Asthma**	_____ **Fainting/Dizziness**	_____ **Joint Replacement**	_____ **Rheumatic Fever**
_____ **Bypass/Pacemaker**	_____ **Gastrointestinal Disease**	_____ **Kidney Problems**	_____ **Sinus Trouble**
_____ **Blood Disorder**	_____ **Heart Attack**	_____ **Leukemia**	_____ **Speech**
_____ **Cancer**	_____ **Heart Murmur**	_____ **Liver Problems**	_____ **Stroke**
_____ **Chemotherapy**	_____ **Heart Problems**	_____ **Low Blood Pressure**	_____ **Thyroid**
_____ **Cough/Dry Mouth**	_____**Headaches/Migraine**	_____ **Mitral Valve Prolapse**	_____ **Ulcers**
_____ **Diabetes (Type____)**	_____**Hayfever**	_____ **Have you ever taken Fen-Phen or Redux?**	

9. If you checked Heart, please specify what type of problem you have? _____
(example: cardiovascular disease, angina, arteriosclerosis, congestive heart failure, artificial heart valve, endocarditis, damaged heart valve, congenital heart disease/defects, etc…)

10. If you checked Joint Replacement (artificial/prosthetics), please specify what kind? _____
(example: hip, knee, elbow, heart valve, organ transplants, titanium rods, plates, etc…)

11. **INFECTIOUS DISEASES:** ***Have you or any member of your family or intimate friends had any contact with any person with the following diseases?***

_____ **Hepatitis (Type_____)**	_____ **Venereal Diseases**	_____ **Herpes**	_____ **Mononucleosis**
_____ **Tuberculosis**	_____ **AIDS**	_____ **HIV**	_____ **Other**

_____ **Are you considered to be in a high risk group for any of these?**

12. Are you pregnant? YES ❑ NO ❑ How many weeks? _____

DENTAL HISTORY:

Is this your first visit to a dentist? YES ❑ NO ❑
If NO, when was your last dental visit? _____

Do you smoke or use snuff? _____ **How often?** _____

Are you wearing any removable dental appliances? YES ❑ NO ❑
*(example: dentures, partials, retainers, etc…)*_____

Have you ever bumped your teeth? YES ❑ NO ❑
(example: car accident, work accident, fight, sports related, etc…)

HOW DID YOU HEAR ABOUT OUR OFFICE?
NEWSPAPER AD ❑ RADIO ❑ INTERNET ❑ YELLOW PAGES ❑
REFERRED BY FRIEND ❑ _____ **OTHER DOCTOR'S OFFICE ❑** _____

Notification of Practices and Policies

I acknowledge that I have received your* Notice of Privacy Practices *containing a more complete description of the uses and disclosures of my health information. I also acknowledge that I have received a copy of the* Financial Policy Notice *of your office and by my signature agree to comply with the financial policy of this office. I understand that I may contact this organization at any time to obtain a current copy of the* Notice of Privacy Practices *and* Financial Policy Notice*. I acknowledge by my signature that I assume full responsibility for payment of my dental account. Also, indicated by my signature, that my information on my health history is accurate to the best of my knowledge and that I assume full responsibility for any misinformation which results in treatment complications for me or transmission of communicable diseases to my dentist, office staff, or other patients. I give my dentist consent to the use of nitrous oxide per my request.

_____ _____
SIGNATURE OF PATIENT OR GUARDIAN **DATED**