H. TALBOTT TEBAY, D.D.S.

Jacqueline Stump, DDS == Matt Stump, DDS == Larry Gamby, DDS == Zach Lynn, DDS

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

Phone: (____)________________ (____) ____________________ (____)________________________**Best time to call**_______________
Home Mobile Work

Email address: ________________________________ **SSN:** _______________ **Employer:** ___________________________

Date of Birth: ______________ **Gender:** _____ **Height:** ______ **Weight:** _______ **Married** ____ **Single** ____ **Child**____ **Other**_____

Contact Info of guardian/responsible party ____
(if applicable)

Emergency Contact: __________________________ **Relationship:** _________________ **Phone:** (_____)_______________

Primary Dental Insurance: _______________________ ID#:_____________________ Group #: _______________

Individual Insured by Primary Dental Insurance:____

Date of Birth:_______________ Social Security Number: ________________Employer:___________________________

Patient's relationship to insured: self_____ spouse_____ child _____ other_____

Insured's address if different than patient's ____

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Secondary Dental Insurance: ______________________________ ID#:_________________ Group #: ____________

Individual Insured by Secondary Dental Insurance: ____

Date of Birth:_______________ Social Security Number: ________________Employer:___________________________

Patient's relationship to insured: self_____ spouse_____ child _____ other_____

Insured's address if different that patient's ____

Medical Physician:__________________________________ ***Last physical examination:***________________

Preferred Pharmacy:_____________________________ ***location***______________________________

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 your care.

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

Were x-rays taken? __________ **Would you like to transfer your records to our office?** _______

List any serious problems you have had with previous dental treatment. ____
____
____

Do you bleed a great deal after tooth extraction or cut, or take aspirin or blood thinners? YES ❑ NO ❑
(*example: Aspirin, Coumadin(Warfarin), Plavix, Lovenox, Aggrenox, Heparin, etc…)*
If you checked yes, which medications? ____

Do you wear any removable dental appliances (*dentures, partials, retainers, etc…)* ____________________________

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

Do you smoke or use tobacco?___________________ **How often?**___________________

(PLEASE CONTINUE ON REVERSE SIDE)
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Indicate which of the following conditions you have or have had.
Check if the answer is "YES"; leave blank for "NO"

_____ ADHD-ADD	_____Allergies	_____Alzheimer's/Dementia	_____Anemia	_____Anxiety/Depression
_____ Arthritis	_____Artificial Joints	_____Aspirin Allergy	_____Asthma	_____Autism
_____ Blood Disease	_____Blood Disorder	_____Blood Thinners	_____Bypass	_____Pacemaker
_____COPD-Lung Problems	_____Cancer	_____Chemotherapy	_____Cholesterol, high	_____Codeine Allergy
_____Cough/Dry Mouth	_____Coumadin Patient	_____Darvocet Allergy	_____Diabetes	_____Eating Disorder
_____Epilepsy/Seizures	_____Essential Tremors	_____Excessive Bleeding	_____Fibromyalgia	_____Fainting/Dizziness
_____GERD	_____HIV/AIDS	_____Head Injuries	_____Headaches	_____Heart Problems
_____Heart Arrhythmia	_____Heart Attack	_____Heart Murmur	_____Hepatitis	_____Herpes
_____High Blood Pressure	_____IV Demerol Allergy	_____IV Dye	_____Iodine	_____Jaundice
_____Keflex Allergy	_____ Kidney Problems	_____Latex Allergy	_____Leukemia	_____Liver Problems
_____ Local Anesthetics	_____Low Blood Pressure	_____Mitral Valve Prolapse	_____Mental Disorders	_____Nervous Disorders
_____ Penicillin Allergy	_____Phenergan/Compazine	_____Pre-Medicate	_____Radiation	_____Red Dye Allergy
_____ Recent Weight Loss	_____Respiratory Problems	_____Rheumatic Fever	_____Seasonal Allergies	_____Sinus Trouble
_____ Speech Problems	_____Steroid Allergy	_____Stroke	_____Sulfa Allergy	_____Sutures
_____ Thyroid	_____Tuberculosis	_____Ulcers	_____Venereal Disease	
_____ Taken Fen-Phen or Redux		_____Autoimmune Disorder		

Please explain/clarify any conditions checked above **(example: Type of heart problem? What kind of joint replacement and when? Pre-med reason?)**
_____
_____
_____
_____

Currently Pregnant: NO___ YES___ If yes, how many weeks_____

Allergies or conditions not listed:
_____
_____

List all medications, drugs, pills or herbal remedies including regular doses of aspirin you take: (or provide a list we may copy)
_____
_____
_____
_____

Whom may we thank for referring you to our office?
REFERRED BY FRIEND _____ OTHER DOCTOR'S OFFICE _____

NEWSPAPER AD ❑ RADIO ❑ INTERNET ❑ YELLOW PAGES ❑

Notification of Privacy 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**