

JOHN A. PORTER D.M.D. --- HEALTH HISTORY AND INFORMATION FORM

The following information is needed to determine how best to serve you. All information given will be confidential.

DATE _____

PATIENT'S NAME _____ BIRTHDATE _____ SEX _____

EMAIL ADDRESS _____ PHONE (Cell) _____

MAILING ADDRESS _____ PHONE (Home) _____

PHONE (Work) _____

OCCUPATION _____ SOC SEC. NO. _____

DRIVER'S LICENSE NO. _____ PHARMACY _____

PRESENT EMPLOYER _____ Adrs & Phne _____

HOW DID YOU LEARN OF THIS OFFICE ? _____

WHY ARE YOU SEEKING DENTAL CARE? _____

If you are presently seeing a Medical Doctor please give Doctor's name and reason for Medical Treatment: _____

Please list all medications that you are presently taking or have taken in the last year (over for extensive lists): _____

Please list or describe any known allergies: _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

- | | YES / NO | | YES / NO |
|--|---|---|---|
| 1. Have you been tested for HIV (AIDS) Virus?..... | <input type="checkbox"/> <input type="checkbox"/> | 11. Stroke?..... | <input type="checkbox"/> <input type="checkbox"/> |
| If yes give date and results: _____ | | 12. Epilepsy or Seizures?..... | <input type="checkbox"/> <input type="checkbox"/> |
| 2. Taken Bisphosphonates (Boniva, Fosamax)?.... | <input type="checkbox"/> <input type="checkbox"/> | 13. Abnormal Bleeding Problems or Blood Disorder?.... | <input type="checkbox"/> <input type="checkbox"/> |
| 3. Rheumatic Fever or Rheumatic Heart Disease? | <input type="checkbox"/> <input type="checkbox"/> | 14. High or Low Blood Pressure?..... | <input type="checkbox"/> <input type="checkbox"/> |
| 4. Pacemaker or Artificial Heart Valves?..... | <input type="checkbox"/> <input type="checkbox"/> | 15. Tuberculosis, Emphysema or other Lung Disease? | <input type="checkbox"/> <input type="checkbox"/> |
| 5. Congenital Heart Lesions, or Heart Murmur?..... | <input type="checkbox"/> <input type="checkbox"/> | 16. Kidney Disease, Infection or Dialysis?..... | <input type="checkbox"/> <input type="checkbox"/> |
| 6. Artificial Joint Replacements?..... | <input type="checkbox"/> <input type="checkbox"/> | 17. Diabetes?..... | <input type="checkbox"/> <input type="checkbox"/> |
| 7. Hepatitis, Jaundice or Liver Disease?..... | <input type="checkbox"/> <input type="checkbox"/> | 18. Asthma, Hay Fever, or Sinus Problems?..... | <input type="checkbox"/> <input type="checkbox"/> |
| 8. Heart Attack, or Heart Problem?..... | <input type="checkbox"/> <input type="checkbox"/> | 19. Do You Smoke?..... | <input type="checkbox"/> <input type="checkbox"/> |
| 9. Stomach or Duodenal Ulcer?..... | <input type="checkbox"/> <input type="checkbox"/> | 20. Orthodontics (Braces)?..... | <input type="checkbox"/> <input type="checkbox"/> |
| 10. Medical Radiation Treatments?..... | <input type="checkbox"/> <input type="checkbox"/> | 21. Are You Pregnant?..... | <input type="checkbox"/> <input type="checkbox"/> |

Please describe any serious difficulties you have had with previous dental treatment: _____

Who should we notify in case of an emergency? _____

OUR OFFICE WOULD LIKE TO GET TO KNOW YOU. PLEASE LIST YOUR HOBBIES AND ENJOYABLE LEISURE TIME ACTIVITIES: _____

ALL PATIENTS PLEASE NOTE:

- Patients are responsible for any difference between charges and insurance payments.
- Parents of minor children are not permitted in the operatory unless requested by the Doctor.
- Patients must promise to keep our office advised of changes in Health History or Medications.
- Patients consent to communication via phone, email, or texts.

SIGNED _____ **RELATIONSHIP** _____

(Form must be signed by Parent or Guardian in case of minor patient.)

REVIEWED _____