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 Adrs & Phne ____________

PRESENT EMPLOYER ____________________ ____________

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
1. Have you been tested for HIV (AIDS) Virus?...... If yes give date and results: ______	☐	☐
2. Taken Bisphosphonates (Boniva, Fosamax)?....	☐	☐
3. Rheumatic Fever or Rheumatic Heart Disease?..	☐	☐
4. Pacemaker or Artificial Heart Valves?...............	☐	☐
5. Congenital Heart Lesions, or Heart Murmur?.......	☐	☐
6. Artificial Joint Replacements?........................	☐	☐
7. Hepatitis, Jaundice or Liver Disease?...............	☐	☐
8. Heart Attack, or Heart Problem?......................	☐	☐
9. Stomach or Duodenal Ulcer?..........................	☐	☐
10. Medical Radiation Treatments?......................	☐	☐
11. Stroke?...	☐	☐
12. Epilepsy or Seizures?.......................................	☐	☐
13. Abnormal Bleeding Problems or Blood Disorder?......	☐	☐
14. High or Low Blood Pressure?.............................	☐	☐
15. Tuberculosis, Emphysema or other Lung Disease?..	☐	☐
16. Kidney Disease, Infection or Dialysis?..................	☐	☐
17. Diabetes?...	☐	☐
18. Asthma, Hay Fever, or Sinus Problems?................	☐	☐
19. Do You Smoke?..	☐	☐
20. Orthodontics (Braces)?.....................................	☐	☐
21. Are You Pregnant?..................	☐	☐

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, fax, mail, email, or texts.

SIGNED ____________________ RELATIONSHIP ____________

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

REVIEWED ____________________