BLUE SKY FAMILY DENTAL
Dr. Amy Li, DMD

DATE:

HEALTH HISTORY & REGISTRATION

PATIENT INFORMATION

NAME: Last First MI Sex: M F Birthdate / /

ADDRESS: CITY STATE ZIP CODE

Home # Business# Cell#

Social Security Number Single/Married Name of Spouse

How would you like to be addressed? E-MAIL ADDRESS

Employer Occupation

Name of closest relative or friend to contact in the event of an emergency? Phone #

Whom may we thank for referring you to us?

INSURANCE INFORMATION

PRIMARY Policy Holder Social Security #/Member ID# Group#

Employer Address/City/Zip

Insurance Carrier Claims Address

SECONDARY Policy Holder Social Security #/Member ID# Group#

Employer Address/City/Zip

MEDICAL HISTORY

THE FOLLOWING INFORMATION IS NECESSARY FOR YOUR DENTAL TREATMENT. YOUR ANSWERS ARE CONFIDENTIAL.

	YES	NO		YES	NO
Do you have any CURRENT HEALTH PROBLEMS?	☐	☐	Are you pregnant?	☐	☐
Are you under a PHYSICIAN'S CARE now?	☐	☐	Are you nursing?	☐	☐
For what?	☐	☐	What medications are you currently taking?	☐	☐
Physician's Name and Phone #					
Do you use cigars/cigarettes, pipe or chewing tobacco? circle			Allergies to any medication or food?		

Are you taking any of the following?	YES	NO	Are you allergic or have reacted Adversely to the following?	YES	NO
Antibiotics or Sulfa Drugs	☐	☐	Local Anesthetic	☐	☐
Anticoagulants (Blood Thinners)	☐	☐	Aspirin	☐	☐
Medicine for High Blood Pressure	☐	☐	Penicillin/Amoxicillin	☐	☐
Cortisone (Steroids)	☐	☐	Other Antibiotics-Please List	☐	☐
Tranquilizers or Antidepressants	☐	☐	Iodine	☐	☐
Antihistamines	☐	☐	Sulfa Drugs	☐	☐
Aspirin	☐	☐	Codeine	☐	☐
Nitroglycerin	☐	☐	Other Narcotics-Please List	☐	☐
Digitalis or Drugs for Heart Trouble	☐	☐	Latex	☐	☐

Please check the appropriate box, if you HAVE NOW or HAVE HAD in the past any of the following diseases or problems.

	YES	NO		YES	NO		YES	NO
Aids/HIV positive	☐	☐	Cough up Blood	☐	☐	Material Allergies (metal, chemicals)	☐	☐
Anemia	☐	☐	Diabetes	☐	☐	Mitral Valve Prolapse	☐	☐
Arthritis (Rheumatism)	☐	☐	Epilepsy	☐	☐	Nervous Problems	☐	☐
Artificial Joints	☐	☐	Fainting	☐	☐	Pacemaker	☐	☐
Artificial or Damaged Heart Valves	☐	☐	Food Allergies	☐	☐	Radiation Treatment	☐	☐
Asthma or Hay Fever	☐	☐	Headaches	☐	☐	Respiratory Disease	☐	☐
Autoimmune Disease/Lupus/Sjogren's	☐	☐	Heart Murmur	☐	☐	Rheumatic/Scarlet Fever	☐	☐
Back Problems	☐	☐	Heart Problems (please describe)	☐	☐	Shingles	☐	☐
Blood Disease	☐	☐				Stroke	☐	☐
Blood Transfusion	☐	☐	Hemophilia (abnormal bleeding)	☐	☐	Surgical Implant	☐	☐
Bruise Easily	☐	☐	Hepatitis	☐	☐	Swelling of Feet or Ankles	☐	☐
Cancer (internal or external)	☐	☐	Herpes	☐	☐	Thyroid Disease or Malfunction	☐	☐
Chemical Dependency	☐	☐	High/Low Blood Pressure	☐	☐	Tuberculosis	☐	☐
Chemotherapy	☐	☐	Kidney Disease or Malfunction	☐	☐	Ulcers/Colitis	☐	☐
Circulatory Problems	☐	☐	Liver Disease	☐	☐	Venereal Disease	☐	☐
Cough (Persistent)	☐	☐						

Do you have any disease, condition, or problem not listed above that you think we should know about? YES/NO _____

If yes, please explain. _____

DENTAL HISTORY

How long since you have seen a dentist? _____

Chief oral complaint? _____

Any previous major dental treatment or oral maxofacial surgery? YES/NO If yes, please explain? _____

It is important that we know about your Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you.

Do you HAVE or do you USE any of the following?

	YES	NO		YES	NO		YES	NO
Unfavorable Dental Experience	☐	☐	Do you have Bad Breath?	☐	☐	Have you worn braces? (Orthodontics)	☐	☐
Apprehensive about Dental Treatment	☐	☐	Burning of Tongue	☐	☐	Are you interested in Invisalign?	☐	☐
Jaw Pain	☐	☐	Swelling or Lumps in the Mouth	☐	☐	Have you had Periodontal		
Unusual sound in ear while eating	☐	☐	Frequent Blisters on Lips or Mouth	☐	☐	(Gum) Treatment?	☐	☐
Difficulty in Opening or Closing	☐	☐	Dry Mouth or Eyes	☐	☐	Do your gums Bleed?	☐	☐
Clenching or Grinding	☐	☐	Mouth Breathing	☐	☐	Are your Gums Tender or Irritated?	☐	☐
Head, Neck or Jaw Injury/Surgery	☐	☐	Food impaction between teeth	☐	☐	Do you have discolored teeth		
Frequent Headaches, Ear or Neck Pain	☐	☐	Sensitive Teeth	☐	☐	that bother you?	☐	☐
Oral Habits (fingernail or cheek biting)	☐	☐	Cold, Hot, Sweets and Pressure (circle)			Are you interested in Bleaching		
Are you unhappy with the appearance of your teeth?				☐	☐	or Cosmetic Treatment?	☐	☐

Please Circle

Frequency of brushing 1X 2X 3X MORE (Each Day)

Texture of your toothbrush? SOFT MEDIUM HARD

Frequency of Flossing? 1X DAY 1X WEEK ____X WEEK

I certify that I have read and understand the above; I acknowledge that my questions, if any, about set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of Patient, Parent or Guardian X _____ Date: _____

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