Chart # ____________________

Drs. Boles, Ham, Dixon, and Boles

Welcome to our practice! We are glad to have you as a patient. We want you to know that here in our office, we provide the highest quality of care and the most up to date services available. We do for our patients what we feel is the best preventative and restorative work. We are not an insurance driven practice, which means what we recommend and provide for you may not always be covered by your insurance, however we have your overall health and well being in mind. The following information about your health history is very important for us to provide you with the best possible dental care in a safe way. ALL questions must be answered completely and accurately. This Health History Questionnaire will become a part of the patients dental record and will be considered confidential information.

PATIENT'S NAME ____________________
First Initial Last

DATE OF BIRTH ____________________

NAME YOU WISHED TO BE CALLED ____________________

SINGLE☐ MARRIED☐ SEPARATED☐ DIVORCED☐ WIDOWED☐

MAILING ADDRESS ____________________

CITY ____________ STATE _____ ZIP ________

IF P.O. BOX, PHYSICAL ADDRESS ____________________

COUNTY ____________________

TELEPHONE: RESIDENCE ____________ BUSINESS ____________

CELL PHONE ____________________

EMAIL ____________________

PATIENT'S OR PARENT'S EMPLOYER ____________________

PRESENT POSITION ____________ HOW LONG HELD ____________

SPOUSE'S NAME ____________________

SPOUSE EMPLOYED BY ____________________

PRESENT POSITION ____________ BUS. PHONE ____________

PATIENT'S OR PARENT'S SOCIAL SECURITY NUMBER ____________________

SPOUSE'S SOCIAL SECURITY NUMBER ____________________

SOMEONE TO NOTIFY IN CASE OF EMERGENCY (NOT LIVING WITH YOU)

____________ ____________
NAME CELL PHONE

WHO WILL PAY THIS ACCOUNT ____________________

OTHER FAMILY MEMBERS WHO ARE PATIENTS ____________________

DENTAL INSURANCE 1ST COVERAGE

EMPLOYEE NAME ____________________

EMPLOYEE DATE OF BIRTH ____________________

EMPLOYER ____________________ #YRS ________

NAME OF INSURANCE CO. ____________________

ADDRESS TO INSURANCE CO. ____________________

IDENTIFICATION # ____________________

SOCIAL SECURITY NUMBER ____________________

DENTAL INSURANCE 2ND COVERAGE

EMPLOYEE NAME ____________________

EMPLOYEE DATE OF BIRTH ____________________

EMPLOYER ____________________ #YRS ________

NAME OF INSURANCE CO. ____________________

ADDRESS TO INSURANCE CO. ____________________

IDENTIFICATION # ____________________

SOCIAL SECURITY NUMBER ____________________

I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM

____________ ____________
DATE NAME

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

____________ ____________
DATE NAME

Name of Your Physician: ____________________ Office Telephone: ____________

Address of Your Physician ____________________

1. Are you in good health? Yes No Don't Know
2. Have you ever been hospitalized, had a major operation or serious illness? .... Yes No Don't Know
   If yes, explain ____________________
3. Date of you last visit to the doctor ____________ Reason for last visit ____________
4. Are you currently receiving treatment or regular medical care by your doctor? .... Yes No Don't Know
   If yes, for what condition(s)? ____________________

MEDICAL HISTORY

Anxieties.. Yes / No
Anemic.. Yes / No
Artificial Heart Valve .... Yes / No
Artificial Joint .... Yes / No
Asthma .... Yes / No
AIDS/HIV Positive.. Yes / No
Breathing Problems.. Yes / No
Cancer .... Yes / No
Chemotherapy.. Yes / No
Diabetic.. Yes / No
Fainting Spells.. Yes / No
Heart Murmur .... Yes / No
Heart Attack.. Yes / No
Any other Heart Problems? .... Yes / No
Explain ____________________________________..
Headaches .... Yes / No
High Blood Pressure.. Yes / No
Hepatitis.. Yes / No
Hemophilia.. Yes / No

Kidney Problems .... Yes / No
Explain ______________________________________
Liver Disease.. Yes / No
Mental Problems .... Yes / No
Nursing .... Yes / No
Pregnant.. Yes / No
Radiation .... Yes / No
Rheumatic Fever .... Yes / No
Seizures .... Yes / No
Sinus Problems .... Yes / No
Stroke .... Yes / No
Thyroid Problems .... Yes / No
Ulcers .... Yes / No
Has your medical doctor requested that you take pre-med (antibiotics)?.. Yes / No
If yes, name antibiotics prescribed by your medical doctor before dental procedures: ________________
____
____

Have you ever had a cardiac exam?____
Any other health problems not listed above? Explain.____
____
____

Please list all medications, dosage and frequency taken.____
____
____
____
____
____

Please list any allergies. ____
____
____

DENTAL HISTORY:

5. How often do you get dental check-ups? ______________________________

6. Have you ever had any specialized dental treatment (other than routine cleanings and fillings)? .... Yes No Don't Know

   If yes, explain ______________________________

7. Have you ever had an unusual reaction to a dental procedure or anesthetic? .... Yes No Don't Know

8. Have you ever experienced prolonged bleeding following dental treatment? .... Yes No Don't Know

   If yes, explain ______________________________

9. Have you had any complications following dental treatment? .... Yes No Don't Know

   If yes, explain ______________________________

10. Have you had any injury to your teeth, jaws, or face? .... Yes No Don't Know

    If yes, explain ______________________________

11. Do you clench or grind your teeth? .... Yes No Don't Know

12. Do you snore or have sleep apnea? .... Yes No Don't Know

13. Have you ever had a sleep study performed? .... Yes No Don't Know

CURRENT DENTAL CONCERNS:

14. What is your major dental concern? ______________________________

15. Are you unhappy with the appearance of your teeth? .... Yes No Don't Know

16. Do your gums bleed when you brush your teeth or when you eat? .... Yes No Don't Know

17. Does food or dental floss catch between your teeth? .... Yes No Don't Know

18. Are some of your teeth becoming loose? .... Yes No Don't Know

19. Are your teeth sensitive to hot, cold, or pressure? .... Yes No Don't Know

20. Do you experience pain or clicking in your jaw joints? .... Yes No Don't Know

21. Are there any sores or growths in your mouth? .... Yes No Don't Know

SIGNATURE OF PATIENT: I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes in my medical or dental status to the dentist at the earliest possible time, and I agree to do so. I give my permission to the dentist to obtain from my physician any additional information regarding my medical history needed to provide me the best dental treatment possible.

PERSON COMPLETING FORM: Signature ______________________________ Date ______________

If other than the patient, indicate relationship: ______________________________

Payment is due at time of service for any amount not covered by insurance.
We accept cash, check, Mastercard, Visa, Discover, and CareCredit.

If we will be filing insurance for you, please have your insurance card ready to show a team member.