NORTH POINT
DENTAL GROUP, LLC

PATIENT HEALTH HISTORY

Name: _____

Phone: □ Cell □ Home _____ Birthdate: _____

Address: _____

E-Mail: _____

Who is your primary care physician? _____

Are you now taking any medications? Yes No

If yes, please list: _____

_____

Have you ever taken bone density drugs (bisphosphonates)? Examples: Boniva, Fosamax, Reclast ..... Yes No

Are you aware of being allergic to, or have you adversely reacted to any medication or substance? ..... Yes No

If yes, please list: _____

Do you have any bleeding disorder, or are you taking any blood thinning medications? ..... Yes No

Indicate which of the following you have had or have at present:

Heart Disease	Yes	No	Kidney Problems	Yes	No	Sleep Apnea	Yes	No
Shortness of Breath	Yes	No	Ulcers	Yes	No	Snoring	Yes	No
High Blood Pressure	Yes	No	Diabetes	Yes	No	Hepatitis (A, B or C)	Yes	No
Arteriosclerosis	Yes	No	Emphysema	Yes	No	Hemophilia	Yes	No
Artificial Heart Valve	Yes	No	Tuberculosis	Yes	No	Liver Disease	Yes	No
Heart Pacemaker	Yes	No	Asthma	Yes	No	Epilepsy or Seizures	Yes	No
Drug Addiction, Alcoholism	Yes	No	Sinus Problems	Yes	No	Fainting or Dizzy Spells	Yes	No
Current Tobacco Use	Yes	No	Cancer or Tumor	Yes	No	Nervousness	Yes	No
Artificial Joints	Yes	No	Radiation Therapy	Yes	No	Psychiatric Treatment	Yes	No
Glaucoma	Yes	No	Immunocompromised	Yes	No			

Do you have any diseases, conditions, or problems not listed? ..... Yes No

If yes, please list: _____

Have you been hospitalized in the last two years? ..... Yes No

If yes, please list why: _____

Are you .... Pregnant: Yes No N/A Nursing: Yes No N/A Taking Birth Control: Yes No N/A

Have you been told, or are you aware that you clench or grind your teeth? □ Day □ Night ..... Yes No

Is your jaw or are your teeth tired when you awaken, or do you ever experience jaw pain? ..... Yes No

Are you happy with the appearance of your teeth? (color, size, shape, alignment) ..... Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency. I will notify the dentist of any health or medication changes. I authorize x-rays, oral exams, study models, photographs, and any other diagnostic aids deemed appropriate to make a thorough dental diagnosis. I authorize treatment, medication, and therapy that may be indicated. I understand there is a very low risk of nerve damage in the mouth from the administration and use of local anesthetics.

_____

Signature of Patient or Guardian Date