Dental Patient Health History Form

PRAIRIE STAR Health Center
non-profit • FQHC

LAST NAME	FIRST	DATE OF BIRTH	AGE

ADDRESS	DATE OF LAST DENTAL EXAM

ARE YOU CURRENTLY BEING TREATED BY A PHYSICIAN? ☐ YES ☐ NO	IF YES, FOR WHAT?

NAME OF PRIMARY CARE PROVIDER	**PREFERRED PHARMACY**

SPECIALIST(S) YOU ARE CURRENTLY SEEING

GENERAL HEALTH

IS YOUR GENERAL HEALTH GOOD?	☐ YES	☐ NO
HAS THERE BEEN A CHANGE IN YOUR OVERALL HEALTH WITHIN THE LAST YEAR?	☐ YES	☐ NO
HAVE YOU BEEN HOSPITALIZED OR HAD A SERIOUS ILLNESS WITHIN THE LAST 3 YEARS?	☐ YES	☐ NO

IF YES, PLEASE EXPLAIN	DATE OF HOSPITALIZATION

HAVE YOU HAD PROBLEMS WITH PRIOR DENTAL TREATMENT?	☐ YES	☐ NO
ARE YOU CURRENTLY IN PAIN?	☐ YES	☐ NO
DO YOU FEEL NERVOUS OR ANXIOUS WHEN GOING TO THE DENTIST?	☐ YES	☐ NO
DO YOU HAVE SPECIAL NEEDS? (WHEELCHAIR BOUND, VISUAL OR AUDITORY IMPAIRMENT, DEVELOPMENTAL DISORDER, ETC.)	☐ YES	☐ NO

IF YES, PLEASE EXPLAIN

PAST AND PRESENT MEDICAL PROBLEMS (PLEASE CHECK AND DESCRIBE)

CARDIOVASCULAR	EYES, EARS, NOSE & MOUTH	ENDOCRINE
☐ HIGH BLOOD PRESSURE	☐ EYE DISEASE	☐ THYROID DISEASE: ☐ HYPO ☐ HYPER
☐ HEART ATTACK	☐ SINUS PROBLEMS	☐ DIABETES
☐ CHEST PAIN	**GASTROINTESTINAL**	☐ EXCESSIVE THIRST
☐ HEART DISEASE	☐ FREQUENT NAUSEA/ VOMITING	☐ DRY MOUTH
☐ HEART MURMURS	☐ GASTROESOPHOGEAL REFLUX DISEA	☐ DIFFICULTY SWALLOWING
☐ PROSTHETIC HEART VALVE	☐ STOMACH PROBLEMS	**RHEUMATOLOGY**
☐ CONGENITAL HEART DEFECT	☐ ULCERS	☐ ARTHRITIS / RHEUMATISM
☐ PACEMAKER	☐ LIVER DISEASE	☐ RHEUMATIC FEVER
GENERAL	☐ HEPATITIS: ☐ A ☐ B ☐ C	☐ INFECTIVE ENDOCARDITIS
☐ FEVER	**INFECTIOUS DISEASE**	☐ ARTIFICIAL JOINT
☐ NIGHT SWEATS	☐ AIDS / HIV	**HEMATOLOGY**
☐ WEIGHT GAIN	☐ HERPES	☐ BLEEDING PROBLEMS
☐ WEIGHT LOSS	☐ VD (syphilis or gonorrhea)	☐ EASY BRUISING
URINARY	☐ SKIN DISEASE	☐ BLOOD TRANSFUSION
☐ KIDNEY DISEASE	**PSYCHOLOGICAL**	☐ ANEMIA
☐ BLADDER DISEASE	☐ ANXIETY	**ONCOLOGY**
PULMONARY	☐ DEPRESSION	☐ CANCER
☐ ASTHMA	☐ SCHIZOPHRENIA	☐ TUMORS
☐ COPD / EMPHYSEMA	☐ BIPOLAR DISORDER	☐ CHEMOTHERAPY
☐ SHORTNESS OF BREATH	☐ OTHER:	☐ RADIATION TREATMENTS
☐ TUBERCULOSIS	**NEUROLOGICAL**	**ALLERGIES**
WOMEN ONLY	☐ DIZZINESS	☐ FOOD
☐ PREGNANT OR NURSING	☐ FAINTING SPELLS	☐ MEDICATIONS
☐ TAKING BIRTH CONTROL PILLS	☐ SEIZURES / EPILEPSY	☐ LATEX
	☐ HEADACHE	PLEASE SPECIFY:
	☐ MIGRAINE	
	☐ STROKE/HARDENING OF ARTERIES	

(Continue on Reverse)

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FAMILY HISTORY OF:		
☐ DIABETES	☐ HEART PROBLEMS	☐ TUMORS
SOCIAL HISTORY		
☐ RECREATIONAL DRUGS	☐ TOBACCO (IN ANY FORM)	☐ ALCOHOL
MEDICATION HISTORY		
☐ BIOPHOSPHONATES (Osteoperosis)	☐ BLOOD THINNERS (Coumadin, Warfarin)	
☐ OTHER MEDICATIONS (Including over-the-counter medications, aspirin, natural remedies, etc.) PLEASE LIST		
SURGERIES Please list any surgeries you have had.		
OTHER PROBLEMS NOT LISTED Please list any other diseases or medical problems NOT listed on this form.		

PATIENT/GUARDIAN SIGNATURE	DATE
PSHC PROVIDER SIGNATURE	DATE

Patient Acknowledgement
of Dental Confirmation Policy

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DENTAL CONFIRMATION POLICY
DUE TO THE GREAT NEED FOR DENTAL SERVICES IN OUR COMMUNITY, PRAIRIESTAR HEALTH CENTER DENTAL CLINIC HAS FOUND IT NECESSARY TO REQUIRE PATIENTS TO CONFIRM THEIR SCHEDULED APPOINTMENTS.
All patient appointment must be confirmed by 2:00pm the day prior to the day of a scheduled appointment.
We will make every attempt to contact patients two (2) days prior to their scheduled appointment to review the procedure, pre-medication (if applicable), insurance information, and co-pay required at the time of service.
If an appointment is NOT confirmed by 2:00pm the day prior to the scheduled appointment, the appointment may be given to another patient awaiting an appointment.
Patients must arrive 15 minutes prior to their scheduled appointment time to complete any necessary paperwork required.
Failure to show for scheduled appointments may cause rescheduling several months in the future. After two (2) no-shows in the dental clinic, the patient's account will be "flagged" for inability to keep appointments for the duration of one (1) year. During this time, the patient may be seen in the dental clinic ONLY on a same day basis, and ONLY if the schedule allows.

PATIENT ACKNOWLEDGEMENT
I certify that I have read, fully understand and accept all terms of the foregoing guidelines.

PATIENT SIGNATURE	DATE