

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 DISEASE	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)

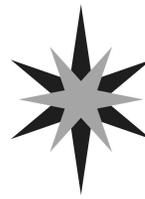
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FAMILY HISTORY OF:		
DIABETES	HEART PROBLEMS	TUMORS
SOCIAL HISTORY		
RECREATIONAL DRUGS	TOBACCO (IN ANY FORM)	ALCOHOL
MEDICATION HISTORY		
BIOPHOSPHONATES (Osteoporosis)	BLOOD THINNERS (Coumadin, Warfarin)	
OTHER MEDICATIONS (Including over-the-counter 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