

Health History Form

Today's Date

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive, or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

PERSONAL INFORMATION

First Name	Last Name	MI
If you are completing this form for another person,	what is your relationship to that person?	
Your Name	Relationship	

rouriname		Relationship
Home Phone	Cell Phone	

E-mail

MEDICAL INFORMATION For the following questions, please mark (X) your responses.

Are you currently under the care of Physician Name	of a physician? Phone	Yes	No	Have you had a serious illness, operation or been hospitalized in the past 5 years? If yes, what was the illness or problem?	Yes	No
Address/City/State/Zip				Are you taking or have you recently taken any prescription or		
Are you in good health?				over the counter medicine(s)? Do you take any blood thinners?		
Has there been any change in yo past year?	-			Do you take aspirin on a regular basis?		
If yes, what condition is being trea	ated?			If yes, please list all, including vitamins, natural or herbal preparations and/or diet supplements:		
Date of last physical exam						
For the following questions mark		Yes	No	Women oner And you.	Yes	No
Do you use controlled substances				Pregnant?		
Do you use tobacco (smoking, sm				Number of weeks		
If so, how interested are you in sto VERY SOMEWHAT	NOT INTERESTED			Taking birth control pills or hormonal replacements?		
Do you drink alcoholic beverages				Nursing?		
If yes, how much alcohol did you	drink in the last 24 hours?					
					Yes	No
Joint Replacement: Have you eve	r had an orthopedic total joint	(hip, I	knee, e	elbow, finger) replacement?		
If yes, date If y	es, have you had any complic	ations	\$?			
Allergies: Are you allergic or hav		Yes	No	Metals	Yes	No
Aspirin				Latex (rubber)		
Penicillin or other antibiotics				lodine		
Barbiturates, sedatives, or sleepir	ng pills			Hay fever/seasonal		
Sulfa drugs				Animals		
Codeine or other narcotics				Food/Other		
				If yes, please specify		

MEDICAL INFORMATION (Continued)

Please mark (X) your response if you have or have had any of the following diseases or problems.

	Yes	No		Yes	No)	Yes		Yes	No
Heart murmur			Blood transfusion			Diabetes type I or type II		Mental health disorders		
Mitral valve prolapse			lf yes, date			Eating disorder		If yes, please specify		
Artificial heart valves						Malnutrition				
Rheumatic fever			Hemophilia			Gastrointestinal disease		Recurrent infections		
Cardiovascular disease			AIDS or HIV infection			GE Reflux/persistent		If yes, type of infection		
Angina			Arthritis							
Arteriosclerosis			Autoimmune disease			Ulcers		Kidney problems		
Congestive heart failure			Rheumatoid arthritis			Thyroid problems		Night sweats		
Coronary artery disease			Systematic lupus			Stroke		Osteoporosis		
Damaged heart valves			erythematosus			Glaucoma		Persistent swollen glands		
Heart attack			Asthma			Hepatitis, jaundice, or liver disease		in neck		
Low blood pressure			Bronchitis					Severe headache/migraines		
High blood pressure			Emphysema					Severe/rapid weight loss		
Congenital heart defects			Sinus trouble			Fainting spells/seizures		STDs/STIs		
			Tuberculosis			Neurological disorders		Excessive urination		
Pacemaker			Cancer/Chemotherapy/			If yes, please specify		ADD		
Rheumatic heart disease			Radiation treatment					ADHD		
Abnormal bleeding			Chest pain upon exertion			Gag Reflex Sensitivity		Sensory Processing Disorder.		
Anemia			Chronic pain			Sleep disorder		Oral Sensory Sensitivity		
								Grai Schoory Constituty		Nic
Has a physician recommer	nded	that	you take antibiotics prior to	your t	reat	tment?		 	Yes	No

Do you have any disease, condition, or problem not listed above that you think I should know about?.....

If yes, please explain

PHARMACY INFORMATION

Pharmacy Name

Pharmacy Phone

Pharmacy Address

SIGNATURE

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my doctor and their staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of their staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Name of Patient/Legal Guardian	
Signature of Dationt/Logal Quardian	Data
Signature of Patient/Legal Guardian	Date

All parties involved agree that this document may be signed electronically. The electronic signatures appearing on this document are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

FOR COMPLETION BY OFFICE

omments:	



Cancellation and No-Show Policy

At Precious Smiles Family Dentistry, we strive to provide exceptional care and to accommodate each patient's scheduling needs. To ensure that all patients have access to timely appointments, we have implemented the following policy:

- Late Cancellation Fee: We kindly request that you notify us at least 24 hours in advance if you need to cancel or reschedule your appointment. Cancellations made with less than 24 hours' notice will incur a \$50 late cancellation fee.
- **No-Show Fee:** If you do not arrive for your scheduled appointment without prior notice, a \$50 no-show fee will be applied to your account.

Please understand that these fees help us cover the costs associated with unfilled appointments and maintain high-quality care for all patients. If you have any questions or concerns regarding this policy, please feel free to discuss them with our staff.

By signing below, you acknowledge and accept the terms of our cancellation and no-show policy.

SIGNATURE

Patient Signature *

Date *