Stanfield Dental PLLC, DBA Glendale Gentle Dentistry, PC

Health History

Name- ____ ❑Male ❑Female

First Middle Last Date of Birth

- Reason for today's visit? ______________________________
- When was your last visit to a dentist? What was it for? ______________________________
- Are you having pain or discomfort at this time? ……………………………….. ❑Yes ❑No
- Do you feel very nervous about having dental treatment? ……………………… ❑Yes ❑No
- Have you ever had a bad experience in a dental office? ………………………... ❑Yes ❑No
- Have you been under the care of a physician during the last two years? .... ❑Yes ❑No
  Physician's name______________________________
  Address______________________________
  Phone Number______________________________
- Are you now taking any medications, drug, pills or use tobacco? .... Yes No
  If yes, please list______________________________
- Are you allergic to or have you reacted adversely to any medications or substances?
- ❑Yes ❑No Aspirin ❑Yes ❑No Codeine ❑Yes ❑No Other
  ❑Yes ❑No Penicillin ❑Yes ❑No Erythromycin if yes, please list______
  ❑Yes ❑No Local Anesthetic ❑Yes ❑No Latex
- Have you ever been a patient in a hospital? .... Yes No
  Please list procedures performed ______________________________
  PREMED is the patients responsibility. Pharmacy info ______________________________
- Have you in the past or do you currently have:
  ❑Yes ❑No Heart Disease/Attack ❑Yes ❑No Epilepsy or Seizures ❑Yes ❑No TMJ Treatment
  ❑Yes ❑No High Blood pressure ❑Yes ❑No Hemophilia ❑Yes ❑No Diabetes
  ❑Yes ❑No Heart Murmur ❑Yes ❑No Artificial Joints ❑Yes ❑No Psychiatric Treatment
  ❑Yes ❑No Rheumatic fever ❑Yes ❑No Venereal Disease ❑Yes ❑No HIV+
  ❑Yes ❑No Heart Surgery ❑Yes ❑No Kidney Disease ❑Yes ❑No Hepatitis B (serum)
  ❑Yes ❑No Mitral Valve Prolapse ❑Yes ❑No Pain in Jaw Joints ❑Yes ❑No Drug addiction
- Do you have any disease, condition or problem that is not listed? …………………….. ❑Yes ❑No
  If yes, please describe______________________________
- For Women Only:
  Are you taking Birth Control Pills? .... ❑Yes ❑No
  Are you pregnant? ....❑Yes ❑No
  If yes, what month? ______________________________

Consent: To the best of my knowledge, the above information on this Health History sheet is as complete and accurate as possible. I understand that without full and accurate information the doctor may not be able to provide me with the best care possible. I hereby authorize the Doctor to take radiographs (X-rays), study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to perform any and forms of treatment, medication & therapy, which may be indicated and I further authorize and consent that the Doctor choose and use such assistance as he/she deems fit.

Signature of Patient (or Responsible Party) ______________________________ Date______________________

Health History Reviewed by Provider ______________________________Date______________________