MONOKIAN
family & cosmetic dentistry
...where beautiful smiles begin

HEALTH HISTORY FORM

Patient Information

1. **Is the patient age 17 or younger?**
   - ○ no
   - ○ yes

2. **Will someone other than the patient be financially responsible for this account?**
   - ○ yes
   - ○ no

3. **Patient Information**

First Name: _____ Last Name: _____ Middle Initial: _____ Nickname: _____

Date of Birth: _____ Email address: _____

Home Address: _____ City, State and Zip: _____

Home Phone: _____ Mobile Phone: _____

Please check if you would like to receive appointment reminders via:
☐ Email ☐ Text

Employer: _____ Occupation: _____

Work phone: _____ Ext.: _____

Marital Status:
○ Single ○ Married ○ Divorced

Name of your spouse: _____ Spouse's employer: _____

If Patient is a Student, Name of School/ College: _____ City and State: _____

Whom may we thank for referring you to our office? _____

Emergency Contact (someone outside of your home): _____

Relationship to Patient _____ Contact's Phone Number _____

4. Information about the Responsible Party

Person Responsible for Account: | Relationship to patient: | Date of Birth:

Address:

Home phone number: | Work Number: | Ext.:

Employer: | Occupation:

Social Security number: | Drivers license #: | State issued:

How would you like to receive your statements?

○ by email ○ mailed to my home ○ by both email and mail

5. Do you have a Flexible Spending Account (FSA) or Health Savings Account (HSA)?

○ yes ○ no

○ not sure

6. Gender of patient

○ Male

○ Female

Medical History

Please fill out this section as accurately and completely as you can. It may take a little extra time, but it will help ensure that we can provide you with the safest, most effective dental care possible.

7. What is the reason for your visit to our office?

_____

_____

_____

_____

8. Please check all items that are part of your medical history.

- ☐ Abnormal Bleeding
- ☐ Alcohol Abuse
- ☐ Allergies
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Arthritis
- ☐ Artificial Bones
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Colitis
- ☐ Congenital Heart Defect
- ☐ Cosmetic Surgery
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Drug Abuse
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ Fever Blisters
- ☐ Frequent Headaches/ Migraines
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis-Type: A, B, C
- ☐ High Blood Pressure
- ☐ HIV + AIDS
- ☐ HPV (Human Papillomavirus)
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pace Maker
- ☐ Pneumocystis
- ☐ Psychiatric Problems
- ☐ Radiation Therapy
- ☐ Reflux
- ☐ Rheumatic Therapy
- ☐ Seizures
- ☐ Shingles
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice
- ☐ Anxiety or Panic Attacks
- ☐ Cataract Surgery
- ☐ Back or Neck Problems (that might prevent you from reclining in a dental chair)
- ☐ Claustrophobia
- ☐ Gagging (especially during dental treatment)
- ☐ Chemotherapy Treatment
- ☐ None of the items above are part of my medical history

9. If you have any other disease, condition, or problem we should know about, please describe.

_____

_____

_____

_____

10. Are you currently receiving chemotherapy drugs, or any medications for the treatment of osteoporosis?

○ no ○ yes

if "yes", list medications here

_____

List medications here

_____

11. Are you taking birth control pills?

○ no

○ yes

12. Are you taking any other medications?

○ no ○ yes

if "yes", list medications here

_____

if "yes", list medications here

_____

13. Are you pregnant?

○ no

○ yes

14. Are you nursing?

○ no

○ yes

15. Do you smoke?

○ no

○ yes

16. Please check any allergies you may have, including any drug allergies:

☐ Aspirin	☐ Codeine	☐ Dental Anesthetics
☐ Erythromycin	☐ Jewelry	☐ Latex
☐ Metals	☐ Penicillin	☐ Tetracycline
☐ Sulfa	☐ Motrin	☐ Other

If "other", please specify

_____

17. Please list any conditions for which you have recently been diagnosed, or are currently being treated:

18. Please provide this additional info

Would you like to discuss options to improve your smile?
○ Yes ○ No

Would you like to discuss options to whiten your teeth?
○ Yes ○ No

Do you snore at night?
○ Yes ○ No

Have you ever been diagnosed with sleep apnea?
○ Yes ○ No

Have you ever used a CPAP device?
○ Yes ○ No

Have you ever responded adversely to medical or dental treatment?
○ Yes ○ No

19. Is there anything else we should know about your medical history?

_____

_____

_____

_____

20. In the event we need to contact your doctor, please provide contact information:

Physician's name: _____

Phone number: _____

21. Name of your previous dentist: or dental practice

_____

Primary Dental Insurance Coverage (skip this section if you already provided this information by phone)

22. Subscriber's name: _____ Address: _____

Relation to Patient: _____ Social Security Number: _____ Date of Birth: _____

Employer Name: _____ Name of Insurance Company: _____ Group Number: _____

Subscriber ID _____ Family Yearly Deductible: _____ Individual Yearly Deductible: _____

Renewal date of plan: _____ Is this a Cobra Account? _____

Secondary Dental Insurance Coverage (if applicable)

23. Subscriber's name: _____ Address: _____

Relation to Patient: _____ Social Security Number: _____ Date of Birth: _____

Employer Name: _____ Name of Insurance Company: _____ Group Number: _____

Subscriber ID _____ Family Yearly Deductible: _____ Individual Yearly Deductible: _____

Renewal date of plan: _____ Is this a Cobra Account? _____

_____ _____

Signature Date