Welcome to Our Practice:

LUX WHITE DENTAL GROUP

HEALTH HISTORY FORM:

Patient Information:

Date: _____ Social Security Number: _____

Name: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Sex: ❑ M ❑ F Age: _____ Birthdate: _____

Marital Status: ❑ Married ❑ Divorced ❑ Single ❑ Widowed ❑ Minor

Patient Employer/School: _____ Occupation: _____

Employer/School Address: _____

Employer/School Phone Number: ( ) _____

Who may we thank for referring you? _____

Phone Numbers:

Home: ( ) _____ Work: ( ) _____ Ext _____ Cell Phone: ( ) _____

Emergency Contact: ( ) _____ Name/Relationship: _____

Insurance:

Subscriber Name: _____ Relation to Patient: _____

Insurance Co. _____ Group #: _____

Is patient covered by an additional insurance? ❑ Yes ❑ No

Subscriber Name: _____ Relation to Patient: _____

Insurance Co. _____ Group #: _____

Medications:

List any medications you are currently taking:

_____

_____

_____

Allergies:

❑ Aspirin ❑ Latex ❑ Sulfa

❑ Codeine ❑ Iodine ❑ Other Drugs

❑ Local Anesthetic ❑ Penicillin _____

See Reverse Side

Dental History:

Reason for today's visit: _____

Former Dentist: _____ City/State: _____

Date of last dental visit: _____ Date of last x-ray: _____

Circle "yes" or "no" to indicate if you have had any of the following:

Bad Breath:	Yes	No	Bleeding gums:	Yes	No
Blisters in lips or mouth:	Yes	No	Burning sensation on tongue:	Yes	No
Chew on one side of mouth:	Yes	No	Cigarette, pipe or cigar smoking:	Yes	No
Clicking or popping jaw:	Yes	No	Dry mouth:	Yes	No
Fingernail biting:	Yes	No	Food collection between teeth:	Yes	No
Grinding teeth:	Yes	No	Gums swollen or tender:	Yes	No
Jaw pain of tiredness:	Yes	No	Lip or cheek biting:	Yes	No
Loosen teeth or broken fillings:	Yes	No	Mouth breathing:	Yes	No
Mouth pain, brushing:	Yes	No	Orthodontic treatment:	Yes	No
Pain around ear:	Yes	No	Periodontal treatment:	Yes	No
Sensitivity to cold:	Yes	No	Sensitivity to hot:	Yes	No
Sensitivity to sweets:	Yes	No	Sensitivity when biting:	Yes	No
Sores or growths in your mouth:	Yes	No			

How often do you floss? _____ How often do you brush? _____

Health History:

Physician's Name: _____ Date of last visit: _____

Circle "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV:	Yes	No	Anemia:	Yes	No	Arthritis, Rheumatism:	Yes	No
Artificial Heart Valves:	Yes	No	Artificial Joints:	Yes	No	Asthma:	Yes	No
Back Problems:	Yes	No	Bleeding abnormally:	Yes	No	Blood Disease:	Yes	No
Cancer:	Yes	No	Chemical Dependency:	Yes	No	Chemotherapy:	Yes	No
Circulatory Problems:	Yes	No	Congenital Heart Lesions:	Yes	No	Cortisone Treatment:	Yes	No
Cough, persistent or bloody:	Yes	No	Diabetes:	Yes	No	Emphysema:	Yes	No
Epilepsy:	Yes	No	Fainting or dizziness:	Yes	No	Glaucoma:	Yes	No
Headaches:	Yes	No	Heart Murmur:	Yes	No	Heart Problems:	Yes	No
Hepatitis Type ____	Yes	No	Herpes:	Yes	No	High Blood Pressure:	Yes	No
Liver Disease:	Yes	No	Kidney Disease:	Yes	No	Low Blood Pressure:	Yes	No
Mitral Valve Prolapse:	Yes	No	Nervous Problems:	Yes	No	Pacemaker:	Yes	No
Psychiatric Care:	Yes	No	Radiation Treatment:	Yes	No	Respiratory Disease:	Yes	No
Rheumatic Fever:	Yes	No	Scarlet Fever:	Yes	No	Shortness of Breath:	Yes	No
Sinus Trouble:	Yes	No	Skin Rash:	Yes	No	Special Diet:	Yes	No
Stroke:	Yes	No	Swollen Neck Glands:	Yes	No	Swollen Feet or Ankles:	Yes	No
Thyroid Problems:	Yes	No	Tonsillitis:	Yes	No	Tuberculosis:	Yes	No
Tumor or growth on head or neck:	Yes	No	Ulcer:	Yes	No	Venereal Disease:	Yes	No
			Weight loss, unexplained:	Yes	No			

Women: Are you pregnant? Yes No Due Date: _____

Taking birth control pills? Yes No Are you nursing? Yes No

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 dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions that I have answered are truthful. I will not hold my dentist, or any other member of his/her 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.

Signature of Patient/Guardian: _____ Date: _____