Kimberly S. CHRISTMAN, DDS
FAMILY AND COSMETIC DENTISTRY

Health History

Thank You For Selecting Us.

To help us meet all your healthcare needs, please print and fill out this form completely in ink. If you have any questions please contact us and we will be happy to help.

Patient Information (confidential)

Name_____Date_____
SS#/SIN_____ Birth Date_____ Home Phone_____
Address_____
City_____ State/Prov._____ Zip/P.C._____
Email_____ Cell Phone_____
Check Appropriate Box: □ Minor □ Single □ Married □ Separated □ Divorced □ Widowed
If Student, Name of School/College_____
City_____ State/Prov._____ Zip/P.C._____Full Time Part Time
Patient or Parent/Guardian's Employer_____ Work Phone_____
Business Address_____
City_____ State/Prov._____ Zip/P.C._____
Patient or Parent/Guardian's Name_____ Employer_____Work Phone_____
Whom May We Thank For Referring You?_____
Person to Contact in Case of Emergency_____ Phone_____

Responsible Party

Name of Person Responsible for this Account_____ Relationship to Patient_____
Address_____ Home Phone_____
Email_____ Cell Phone_____
Drivers License #_____ Birth Date_____ Financial Institution_____
Employer _____Work Phone_____SS/SIN_____
Is this Person Currently a Patient in our Office? Y□ N□
For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.
□ Cash □ Personal Check □ Credit Card □ Visa □ Mastercard □ I wish to discuss the office's payment policy.

Insurance Information

Name of Insured_____ Relationship to Patient_____
SS#/SIN_____ Birth Date_____ Date Employed_____
Name of Employer_____ Union or local #_____ Work Phone_____
Employer Address_____
City_____ State/Prov._____ Zip/P.C._____
Insurance Company _____ Group #_____ Policy/I.D.#_____
Ins. Co. Address_____
City_____ State/Prov._____ Zip/P.C._____
How Much is Your Deductible?_____ How Much Have You Used? _____ Max Annual Benefit_____

Do You Have Any Additional Insurance? Y☐ N☐ If Yes Complete the Following:

Name of Insured_____ Relationship to Patient_____
SS#/SIN_____ Birth Date_____ Date Employed_____
Name of Employer_____ Union or local #_____ Work Phone_____
Employer Address_____
City_____ State/Prov._____ Zip/P.C._____
Insurance Company _____ Group #_____ Policy/I.D.#_____
Ins. Co. Address_____
City_____ State/Prov._____ Zip/P.C._____
How Much is Your Deductible?_____ How Much Have You Used? _____ Max Annual Benefit_____

Patient Medical History

Physician_____ Office Phone _____ Date of Last Exam_____

1. Are you under medical treatment now? Y☐ N☐
2. Have you ever been hospitalized for a surgical operation or serious illness in the last five years? If yes, please explain Y☐ N☐
_____
_____

3. Are you taking any medication(s) including non-prescription medicine? Y☐ N☐
If yes, what medication(s) are you taking?
_____
_____
_____

4. Have you ever taken Fen-phen/Redux? Y☐ N☐
5. Do you use tobacco? Y☐ N☐
6. Do you use controlled substances? Y☐ N☐
7. Are you wearing contact lenses? Y☐ N☐
8. Have you had any of the following?

9. Are you allergic to or have you had any reactions to any of the following:

Local anesthetics (e.g. novocaine)	Y☐ N☐
Penicillin or any other Antibiotics	Y☐ N☐
Sulfa Drugs	Y☐ N☐
Barbiturates	Y☐ N☐
Sedatives	Y☐ N☐
Lodine	Y☐ N☐
Aspirin	Y☐ N☐
Any Metals (e.g. nickel, mercury etc.)	Y☐ N☐
Latex Rubber	Y☐ N☐
Other_____	Y☐ N☐

10. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than three weeks)? Y☐ N☐
11. Women Only:
Are you, or do you think you may be pregnant? Y☐ N☐
Are you nursing? Y☐ N☐
Are you taking oral contraceptives? Y☐ N☐

High blood pressure	Y☐ N☐	Heart Disease	Y☐ N☐	Chest Pains	Y☐ N☐
Heart Attack	Y☐ N☐	Cardiac Pacemaker	Y☐ N☐	Easily Winced	Y☐ N☐
Rheumatic Fever	Y☐ N☐	Heart Murmur	Y☐ N☐	Stroke	Y☐ N☐
Swollen Ankles	Y☐ N☐	Angina	Y☐ N☐	Hay Fever/Allergies	Y☐ N☐
Fainting/Seizures	Y☐ N☐	Frequently Tired	Y☐ N☐	Tuberculosis	Y☐ N☐
Asthma	Y☐ N☐	Anemia	Y☐ N☐	Radiation therapy	Y☐ N☐
Low Blood Pressure	Y☐ N☐	Emphysema	Y☐ N☐	Glaucoma	Y☐ N☐
Epilepsy/Convulsions	Y☐ N☐	Cancer	Y☐ N☐	Recent Weight Loss	Y☐ N☐
Leukemia	Y☐ N☐	Arthritis	Y☐ N☐	Liver Disease	Y☐ N☐
Diabetes	Y☐ N☐	Heart Trouble	Y☐ N☐	AIDS/HIV Infection	Y☐ N☐
Hepatitis/Jaundice	Y☐ N☐	Respiratory Problems	Y☐ N☐	Sexually Transmitted Disease	Y☐ N☐
Mitral Valve Prolapse	Y☐ N☐	Thyroid Problem	Y☐ N☐	Joint Replacement or Implant	Y☐ N☐
Stomach Troubles/Ulcers	Y☐ N☐	Kidney Disease	Y☐ N☐	Other_____	Y☐ N☐

Patient Dental History

Name/Location of Previous Dentist_____ Date of Last Exam_____

1. Do your gums bleed while brushing or flossing?	Y☐	N☐
2. Are your teeth sensitive to hot or cold liquids/foods?	Y☐	N☐
3. Are your teeth sensitive to sweet or sour liquids or foods?	Y☐	N☐
4. Do you feel pain in any of your teeth?	Y☐	N☐
5. Do you have any sores or lumps in or near your mouth?	Y☐	N☐
6. Have you had any head, neck or jaw injuries?	Y☐	N☐
7. Have you ever experienced any clicking in your jaw?	Y☐	N☐
8. Have you ever experienced any pain (joint, ear, side of face)?	Y☐	N☐
9. Have you ever experienced any difficulty in opening or closing your jaw?	Y☐	N☐
10. Have you ever experienced any difficulty in chewing?	Y☐	N☐
11. Do you have frequent headaches?	Y☐	N☐
12. Do you clench or grind your teeth?	Y☐	N☐
13. Do you bite your lips or cheeks frequently?	Y☐	N☐
14. Have you ever had difficult extractions in the past?	Y☐	N☐
15. Have you ever had any prolonged bleeding following an extraction?	Y☐	N☐
16. Have you had any orthodontic treatment?	Y☐	N☐
17. Do you wear dentures or partials? If yes, date of placement_____	Y☐	N☐
18. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	Y☐	N☐
19. Do you like your smile?	Y☐	N☐

Authorization and Release

I certify that I have read and understand the above information to be the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I Authorize the Dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I realize and request my insurance company to pay directly to the Dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

_____

Signature of Patient/Responsible Party Date

Doctor's Comments_____

_____

_____

Signature _____Date _____