



Ohana Dental

DENTAL HEALTH HISTORY UPDATE (CONFIDENTIAL)

Date _____

PATIENT INFORMATION

Name _____ Insurance Change? _____
Last Name First Name Initial

Home Phone # _____ Work Phone # _____

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Have you had any serious illnesses or operations? _____ If yes, describe _____

Have you ever been told to take a pre-medication before dental treatment? Yes No

Have you ever taken Osteoporosis (low bone density) medications/bisphosphonates? Yes No

WOMEN: Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Check (✓) if you have or have had any of the following:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Cough up Blood | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Dialysis | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Back Problem | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Fainting | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Chemotherapy | Describe: _____ | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Venereal Disease |

MEDICATIONS

ALLERGIES

List medications you are currently taking: _____

Pharmacy Name _____

Phone _____

Aspirin Penicillin

Barbiturates (sleeping pills) Sulfa

Codeine Other _____

Local Anesthetic _____

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ Signature _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____

and assign directly to Ohana Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____ Relationship _____ Date _____