HEALTH AND PATIENT HISTORY

Where kindness & dentistry meet.

Dr. JEFF CALDWELL
FAMILY DENTISTRY
212 E. 5th St. East Liverpool, Ohio 43920
(330) 385-9496

Today's Date _____

Name: _____
First Middle Last

I prefer to be called: _____ Male___ Female___
Birthdate_____Age_____ Social Security # _____
Address _____
E-Mail_____
City_____State_____ Zip Code _____
Home Phone #_____ Cellular phone #_____ Office # _____
Occupation_____
Employer/School address_____
Work Phone/School #_____ ext_____
Single___ Married___ Divorced___Widowed___ Separated ___Partnered for _____ years
Whom may we thank for referring you? _____
Spouse Information: Name :_____ Birthdate:_____ Social Security # _____
Employer_____
Work # _____ext_____ Alt. Phone#_____ Cellular #_____
In case of an emergency, please contact : _____ **Phone #**_____
Relationship to patient_____
Dental Insurance
Responsible party_____ Relationship to patient_____
Insurance Company_____ Group #_____
Is patient covered by any additional insurance? Yes____ No_____
Subscriber's Name_____ Birthdate_____ Social Security #_____
Relationship to patient_____ Group #_____

ASSIGNMENT AND RELEASE I certify that I, and /or my dependent(s) have insurance coverage with _____ and assign directly to Dr._ _____
Name of Insurance Company(s)

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 authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and my disclose such information to the above-named insurance Company(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will when my current treatment plan is completed or one year from date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian, or Personal Representative

_____ _____
Date Relationship to Patient

HEALTH HISTORY

Physician's Name_____ Date of last visit_____

Have you ever used bisphosphonate medication?

Common brand names are Fosamax, Actonel, Didronel, and Boniva. Yes____ No____

Have you had a serious illness, operation or have been hospitalized in the past 5 years?

If yes, what illness or problem_____

_____

Do you take any blood thinners i.e: Coumadin(Warfarin), Pradaxa, Eliquis, Xarelto, Savaysa _____Yes___ No___

List of current medications/dosage:_____

_____

Place a mark on "Yes" or "No" to indicate if you have or had any of the following:

Aids/HIV	Yes ___ No___	Epilepsy	Yes ___ No___	Respiratory disease	Yes ___ No___
Alcohol dependency	Yes ___ No___	Fainting or dizziness	Yes ___ No___	Seizures	Yes ___ No___
Anemia	Yes ___ No___	Glaucoma	Yes ___ No___	Shortness of breath	Yes ___ No___
Arthritis	Yes ___ No___	Headaches(reoccurring)	Yes ___ No___	Shingles	Yes ___ No___
Artificial joints	Yes ___ No___	Heart Murmur	Yes ___ No___	Sinus trouble	Yes ___ No___
Asthma	Yes ___ No___	Hepatitis type____	Yes ___ No___	Skin rash	Yes ___ No___
Autoimmune disease	Yes ___ No___	Herpes	Yes ___ No___	Steroid therapy	Yes ___ No___
Back problems	Yes ___ No___	High blood pressure	Yes ___ No___	Swollen feet or ankles	Yes ___ No___
Thyroid problems	Yes ___ No___	Jaw pain	Yes ___ No___	Liver disease	Yes ___ No___
Tuberculosis	Yes ___ No___	Blood disease	Yes ___ No___	Kidney disease	Yes ___ No___
Cancer	Yes ___ No___	Psychiatric care	Yes ___ No___	Jaundice	Yes ___ No___
Congenital Heart Disease	Yes ___ No___	Mitral Valve Prolapse	Yes ___ No___	Ulcer	Yes ___ No___
Cortisone treatment	Yes ___ No___	Nervous problems	Yes ___ No___	Osteoporosis	Yes ___ No___
defibrillator	Yes ___ No___	Do you snore	Yes ___ No___	Drug dependency	Yes ___ No___
Paget's disease	Yes ___ No___	Do you chew gum?	Yes ___ No___	Emphysema	Yes ___ No___

Bleeding abnormally, with extractions or surgery Yes ___ No___ Pacemaker or other form? Yes ___ No___

Do you have times at night that you stop breathing? Yes ___ No___ Tumor or growth head or neck Yes ___ No___

Do you smoke or use tobacco in any Yes ___ No___ Weight loss, unexplained Yes ___ No___

Cough, persistent or bloody Diabetes Yes ___ No___ Do you have CPAP machine? Yes ___ No___

Women Only

Are you pregnant? Yes ___ No___ Due date_____ Are you nursing? Yes ___ No __

Taking birth control Yes ___ No___

Dental Histor

Former Dentist_____ City/State_____ Date of last dental visit_____

Why did you leave your previous dentist? _____

Do you currently have pain in your mouth? Yes___ No___

Please a mark "Yes" or "No" to indicate if you have had any of the following:

Bleeding gums	Yes___No___	Gums swollen or tender	Yes___No___	Do you brush daily	Yes ___ No___
Clicking or popping jaw	Yes___No___	Jaw pain	Yes___No___	Do you floss daily	Yes ___ No___
Dry mouth	Yes___No___	Loose or broken teeth	Yes___No___	Do you use mouth rinse	Yes ___ No___
Food collection between the teeth	Yes ___ No___			Have you had braces	Yes___No___
Periodontal/gum disease	Yes___No___	Grinding teeth	Yes___No___	Sensitive teeth	Yes___No___

Are you happy with the way your smile looks? Yes___No___ If not, what would you change? _____