Cañada Hills Dental – Patient Health History

Today's date
/ /

Patient Name:	Nickname:	Birth Date:	Sex:	Home Ph:	Work Ph:	Cell Ph:	Marital Status:

Address: | City, State, Zip:

E-mail Address:

Patient's Social Security#:	Responsible Party for Payment:	Referred By:

Patient's Physician's Name:	Phone:	Preferred Pharmacy:	Phone:

Patient Medications:

	Are you taking Bisphosphonate Medications?	Are you taking birth control pills? Circle: Yes or No

Medical Alerts: | Medication Allergies:

Do you smoke tobacco? Circle: Yes or No	**Women:** Are you pregnant? Circle: Yes or No Are you nursing? Yes or No

DENTAL Insurance

Insured Employer:	Name of Policy Holder:	Group#:	Policy Holder SS#:	Policy Holder Date Of Birth:

Insurance Company:	Address:	City, State, Zip:

Sign below for: 1. Release of Patient Information to Insurance Company. 2. Direct Insurance payments to Cañada Hills Dental

Sign: Date:

Please Place Mark in Y (yes) or N (no) box for ALL the following:

Y N	Conditions:	Y N	Conditions:	Y N	Conditions:	Y N	Conditions:	Y N	Allergies:
☐☐	Abnormal Bleeding	☐☐	Cosmetic Surgery	☐☐	Hemophilia	☐☐	Radiation Therapy	☐☐	Aspirin
☐☐	Alcohol Abuse	☐☐	Diabetes	☐☐	Hepatitis A	☐☐	Rheumatic Fever	☐☐	Codeine
☐☐	Allergies	☐☐	Difficulty Breathing	☐☐	Hepatitis B	☐☐	Seizures	☐☐	Dental Anesthetics
☐☐	Anemia	☐☐	Drug Abuse	☐☐	High Blood Pressure	☐☐	Shingles	☐☐	Erythromycin
☐☐	Angina Pectoris	☐☐	Emphysema	☐☐	HIV or AIDS	☐☐	Sickle Cell Disease	☐☐	Jewelry
☐☐	Arthritis	☐☐	Epilepsy	☐☐	Kidney Problems	☐☐	Sinus Problems	☐☐	Latex
☐☐	Artificial Joints	☐☐	Fainting Spells	☐☐	Liver Disease	☐☐	Stroke	☐☐	Metals
☐☐	Artificial Heart Valve	☐☐	Fever Blisters	☐☐	Low Blood Pressure	☐☐	Thyroid Problems	☐☐	Penicillin
☐☐	Asthma	☐☐	Frequent Headaches	☐☐	Mitral Valve Prolapse	☐☐	Tuberculosis	☐☐	Tetracycline
☐☐	Blood Transfusion	☐☐	Glaucoma	☐☐	Osteoporosis	☐☐	Ulcers	Other:	
☐☐	Cancer/Chemotherapy	☐☐	Heart Murmur	☐☐	Pace Maker	☐☐	Venereal Disease		
☐☐	Colitis	☐☐	Heart Attack	☐☐	Pneumocystis	☐☐	Yellow Jaundice		
☐☐	Congenital Heart Defect	☐☐	Heart Surgery	☐☐	Psychiatric Problems				

If answered Yes to any above conditions, please explain (Include dates):

The information above is true and accurate to the best of my knowledge and recollection.

Sign:_____ Date:_____