# HEALTH HISTORY FORM

**Patient name**:_____**Date of birth**:_____/_____/_____

**Address**:_____**City:**_____

**State:_____Zip**:_____**Email Address**:_____

**SS#**_____**_____ Employer/Company name**:_____

**Primary Phone**:_____**Cell Phone**:_____

**Spouse/Emergency Contact**_____**Phone:**_____

**Parent/Guardian** (if patient is under 18):_____

Parent/Guardian Address:_____

Parent/Guardian Primary Phone:_____ Cell Phone:_____

**Insured Subscriber Name**:_____**SS# or ID#**_____

**Insurance Company**:_____Insured's Employer Name:_____

Are you **allergic** or have you had an adverse reaction to (please circle): **NONE** Penicillin Erythromycin Ibuprofen

Aspirin Latex Codeine Anesthetics Other:_____

**Please list all medications that you are currently taking:** _____

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**Do you have or have you had any of the following (please circle from the list below, if none, circle *NONE*):**

**NONE** Anemia Asthma Heart Disease Rheumatic Fever Epilepsy Heart Murmur Ulcers

Kidney Disease Artificial Heart Valve Joint Replacement Cancer Radiation Chemotherapy Pacemaker

Tuberculosis Depression Anxiety Hepatitis A/B/C/D Stroke Fainting or Seizures HIV/AIDS

Cortisone or Steroids Frequent Headaches Thyroid Disease Bladder Disease Liver Disease Arthritis

Persistent Cough Herpes or other STD Glaucoma Diabetes Type I or II High Blood Pressure

Low Blood Pressure Alcohol or Drug Abuse Osteoporosis/Osteopenia or other Bone Conditions

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Are you/have you taken bisphosphonates including but not limited to Fosamax, Actonel, Boniva, Reclast **YES NO**

Are you pregnant or nursing? **YES NO** Are you currently taking blood thinners? **YES NO**

Do you premedicate with antibiotics before a dental procedure due to heart/joint replacement? **YES NO**

Do you have any condition or problem **NOT** listed above that we need to know about? _____

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We do have options for **SEDATION**. If you feel **ANXIOUS** about root canal therapy, please let us know. We would be happy to discuss our sedation options with you. Are you interested? **YES NO**

I authorize the release of any dental information necessary in order to process my insurance claims. I authorize payment of dental benefits to Winter Springs Endodontics for professional services rendered. I agree that I am responsible for all dental fees and that my insurance is filed as a courtesy to me. I am responsible for any outstanding insurance balance.

PATIENT SIGNATURE:_____DATE:_____