WEST CHESTER DENTAL GROUP

Health History

Name _____ Date of Birth_____/_____/_____

Address_____

Home Phone _____ Cell Phone_____

Email Address_____

Current Dental Insurance Company _____

Subscriber_____Relationship to Patient_____

Subscriber DOB _____Subscriber SSN_____/_____/_____

Does patient have or has had any of the following conditions? Check ALL that apply.

___NO MEDICAL CONCERNS OR CONDITIONS

___Alzheimer's Disease or Dementia
___Anemia, Blood Disorder, Abnormal Bleeding
___Arthritis, Fibromyalgia, Autoimmune Disease
___Artificial Limb, Joint Replacement or Implant
___Asthma, Bronchitis, COPD, Breathing Problems
___Cancer, Chemotherapy/Radiation
___Depression, Anxiety, Bipolar, or Mental Issues
___Diabetes
___Drug/Alcohol Abuse or Rehab
___Excessive Bleeding
___Fainting, Dizziness or Seizures
___Heart Disease or Stroke
___Heart Surgery, Pacemaker, Bypass or Stent
___Hepatitis, Jaundice or Liver Disease
___Heart Murmur or Rheumatic Fever
___High Blood Pressure
___HIV/AIDS
___Hyperactivity, ADD, ADHD, OCD, or ODD
___Hyperthyroid or ___Hypothyroid
___Kidney Disease or Dialysis
___Medication or Iv for Osteoporosis
___Sleep Apnea
___Stomach/ Intestinal Ulcers, Crohn's
___Tuberculosis

Do you ___Smoke ___Vape ___Use Cannabis ___Dip? **Check ALL that apply**

Are you Pregnant? ___Yes ___No

Does patient have any disease, condition, or handicap not listed above?

Please Explain_____

Is the patient under the care of a physician for any illness, health problem or routine care?

Name of Physician_____ Phone #_____

PLEASE CONTINUE ON THE OTHER SIDE >>>>>

Drugs and Medications

Is the patient taking any prescription drugs or over-the-counter medications?
(If, you have a list of your medications, please write "See List" below, and give it to the staff)

Name of Drug or Medication:	Condition being treated:
_____	_____
_____	_____
_____	_____
_____	_____

Allergies or Side Effects to Any of the Following Drugs or Medications **Please check ALL that apply.**

___**NO KNOWN ALLERGIES**

___Novocaine	___Penicillin
___Xylocaine	___Codeine
___Aspirin	___Latex
___Ibuprofen	___Sulfa
___Amoxicillin	___Bactrim

Other allergies not listed above _____

To The best of my knowledge, the above questions have been accurately answered, and I grant permission for the dentist and staff to perform the dental treatment necessary. I understand that providing incorrect information or withholding information can be dangerous to my health, and it is my responsibility to inform the dental staff of any changes in medical status.

Patient Signature (or Parent/Guardian):

_____Date_____

Print Name _____

Relationship to Patient _____

Dentist Signature:

_____ Date_____