Linda G. Goltz, D.D.S.
Abby L. King, D.D.S.

office@GenerationsDentistry.com
989-686-7174

Generations
FAMILY DENTISTRY

Patient Health History

Patient name: _____ Birth date: _____

Chief concern: (Why are you seeking dental care?) _____

Are you in good health? ☐ Yes ☐ No

Are you currently under the care of a physician? ☐ Yes ☐ No

Please list your family physician:

Name: _____

Address: _____

Phone: _____

Medical History

1. Do you have (or previously had) any of the following?

a. Allergic reaction:

☐ Latex ☐ Penicillin ☐ Aspirin
☐ Codeine ☐ Local Anesthetics ☐ Other

If yes, what kind of reaction?

☐ Sweaty ☐ Dizzy ☐ Nausea
☐ Palms itch ☐ Anaphylaxis

b. Heart-related conditions including:

☐ Heart attack ☐ Stroke ☐ Angina
☐ High blood pressure ☐ Irregular heartbeat
☐ Artificial heart valve
☐ Rheumatic fever, rheumatic heart disease, previous bacterial endocarditis
☐ Congenital heart disease

c. Immunosuppressive conditions:

☐ Steroid therapy (e.g. Prednisone)
☐ Radiation or cancer therapy
☐ Rheumatoid arthritis
☐ HIV
☐ SLE (Lupus)
☐ Organ transplant
☐ Other

d. Artificial joints:

☐ Hip ☐ Knee ☐ Ankle ☐ Shoulder

Date(s) placed: _____

e. ☐ **Other artificial implants or devices**

f. ☐ **Bleeding problems, anemia, blood diseases**

g. ☐ **Diabetes:** ☐ Type I ☐ Type II

h. ☐ **Thyroid disease**

i. ☐ **Nervous system disease or seizures**

j. ☐ **Kidney disease**

k. ☐ **Hepatitis** (A, B, C, D, or E), **other liver disease**

l. ☐ **Muscle or joint disease or arthritis**

m. ☐ **Asthma, tuberculosis, other lung disease**

n. ☐ **Stomach or intestinal disease**

o. ☐ **Mental health condition:**

Please specify: _____

p. ☐ **Physical or mental disabilities that may require special care**

q. ☐ **Impairment of hearing, sight or speech**

r. ☐ **Do you have or have you ever been treated for cancer?**

Patient Health History (Continued)

Yes No

☐ ☐ **2. Are you or could you be pregnant?** **Are you nursing?** ☐ Yes

☐ ☐ **3. Do you have any disease, condition, or problem not listed here?**

Describe: _____

☐ ☐ **4. Most recent hospitalization or surgery:** _____ Date: _____

☐ ☐ **5. Are you, or have you ever been addicted to a chemical substance?**

(Ex. Alcohol, prescription drugs, heroin, meth, cocaine, other)

☐ ☐ **6. Do you smoke or use smokeless tobacco?**

How interested are you in stopping your tobacco use?

☐ Very interested ☐ Somewhat interested ☐ Not at all interested

☐ ☐ **7. Have you undergone bisphosphonate drug therapy?** Type: ☐ Oral ☐ Intravenous

(Ex. Aredia, Zometa, Boniva, Reclast, Actonel, Fosamax, other)

8. Please list any prescription, over the counter, or herbal supplements you are currently taking:

_____

_____

_____

Dental History

Yes No

☐ ☐ **9. Do you have regular dental check-ups?** Date of last exam: _____

☐ ☐ **10. Have you ever had any trouble associated with previous dental treatment?**

If yes, please explain: _____

☐ ☐ **11. Have you noticed any lumps or sores in your mouth?**

☐ ☐ **12. Have you ever injured your face, jaws or teeth?**

☐ ☐ **13. Do you suffer from pain in the mouth, face, eyes, neck or throat?**

☐ ☐ **14. Are you happy with the appearance of your teeth?**

☐ ☐ **15. Do you want to save your teeth?**

☐ ☐ **16. Has fear ever prevented you from seeking dental treatment?**

☐ ☐ **17. Are you allergic to any metals or dental materials?**

Generations
FAMILY DENTISTRY

Our Family Caring For Yours

18. Types of dental treatment you have had in the past:

☐ Orthodontics (braces) ☐ Dentures ☐ Root canal ☐ Implant

☐ Periodontal (gum) treatment ☐ Oral surgery ☐ TMJ treatment ☐ Fillings

19. Former dentist: _____

Your signature below shall constitute your "Signature on File" with your insurance company (if applicable) for assignment of your insurance benefits to Generations Family Dentistry and the release of your information to your insurance carriers.

– Payment of your entire balance is due at the time of service –

Signature of Patient or Guardian: _____ Date: _____

Initial _____ Date_____ Initial _____ Date_____ Initial _____ Date_____

Initial _____ Date_____ Initial _____ Date_____ Initial _____ Date_____

Initial _____ Date_____ Initial _____ Date_____ Initial _____ Date_____