VividDental

Phone: 919-231-3251
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3693 New Bern Ave.
Raleigh, NC 27610

HEALTH HISTORY

Please fill in the following information. Your answers are for our records only and will be kept strictly confidential subject to applicable laws. Please note that you will be asked some questions concerning your health. The information is vital to allow us to provide the best care possible.

GENERAL INFORMATION

Patient Name: _____

Patient DOB: _____ Gender: _____

Email Address: _____

Home Phone: _____ Mobile: _____

Mailing Address: _____

_____

EMERGENCY INFORMATION

Emergency Contact: _____

Emergency #: _____

Family Doctor: _____

Family Doctor Phone: _____

☐ Has the main contact (usually a parent or guardian) changed since your last visit?

☐ Has the main person responsible for payment (usually a parent or guardian) changed since your last visit?

OTHER INFORMATION

Social Security #: _____ Occupation: _____

Has your insurance changed since your last visit?

_____

☐ Please text me appointment reminders.

☐ Please email me appointment reminders.

DENTAL INFORMATION

- [ ] Do your gums bleed when you brush or floss?
- [ ] Are your teeth sensitive to cold, hot, sweets or pressure?
- [ ] Does food or floss catch between your teeth?
- [ ] Have you had any periodontal (gum) treatment?
- [ ] Have you had any orthodontic (braces) treatment?
- [ ] Have you had any issues with past dental treatment?
- [ ] Is your home water supply fluorinated?
- [ ] Do you drink bottled or filtered water?
- [ ] Are you experiencing any dental pain or discomfort?
- [ ] Do you have ear aches or neck pain?
- [ ] Do you have clicking, popping or discomfort in your jaw?
- [ ] Do you grind your teeth?
- [ ] Do you have sores or ulcers in your mouth?
- [ ] Do you wear partial dentures?
- [ ] Do you wear full dentures?
- [ ] Have you had a serious injury to your head, neck or mouth?

MEDICAL INFORMATION

Allergies

- [ ] Acetaminophen/Tylenol
- [ ] Codeine
- [ ] Food
- [ ] Acrylic
- [ ] Latex
- [ ] Morphine
- [ ] Tetracycline
- [ ] Demerol
- [ ] Hay fever/seasonal
- [ ] Animals
- [ ] Erythromycin
- [ ] Local anesthetic
- [ ] Penicillin
- [ ] Other
- [ ] Ibuprofen/Motrin/Advil
- [ ] Aspirin
- [ ] Fluoride
- [ ] Iodine
- [ ] Metals
- [ ] Sulfa

_____

Reactions

_____

CONDITIONS

- [ ] Abnormal/excessive bleeding
- [ ] Angina
- [ ] Blood transfusion
- [ ] Cardiovascular disease
- [ ] Damaged heart valves
- [ ] Epilepsy
- [ ] GE Refulx/persistent heartburn
- [ ] Heart attack
- [ ] Hepatitis, jaundice or liver disease
- [ ] Low pain tolerance
- [ ] Night sweats
- [ ] Persistent swollen glands in neck
- [ ] Rheumatic heart disease
- [ ] Sexually transmitted infection (STI)
- [ ] Thyroid problems
- [ ] TMJ Disorder
- [ ] AIDS or HIV
- [ ] Anxiety
- [ ] Autoimmune disease
- [ ] Breathing problems/ respiratory disease
- [ ] Chest pain upon exertion
- [ ] Diabetes
- [ ] Fainting spells or seizures
- [ ] Glaucoma
- [ ] Heart murmur
- [ ] High blood pressure
- [ ] Malnutrition
- [ ] Osteoporosis/Paget's disease
- [ ] Psychiatric Care
- [ ] Rheumatoid Arthritis
- [ ] Sinus Trouble
- [ ] Tuberculosis
- [ ] Alzheimer's/dementia
- [ ] Arteriosclerosis
- [ ] Back problems
- [ ] Bronchitis
- [ ] Chronic pain
- [ ] Eating disorder
- [ ] Frequent headaches
- [ ] Gout
- [ ] Heart rhythm disorder
- [ ] Kidney problems
- [ ] Mitral valve prolapse
- [ ] Other congenital heart defects
- [ ] Recurrent infections
- [ ] Severe headaches/migraines
- [ ] Stroke
- [ ] Sinus Trouble
- [ ] Tumors or growths
- [ ] Anemia
- [ ] Arthritis
- [ ] Blood disease
- [ ] Cancer/chemotherapy/ radiation
- [ ] Congestive heart failure
- [ ] Gastrointestinal Disease
- [ ] Hearing difficulties
- [ ] Hemophilia
- [ ] Low blood pressure
- [ ] Neurological disorders
- [ ] Pacemaker
- [ ] Rheumatic fever
- [ ] Severe or rapid weight loss
- [ ] Systemic lupus erythematosus
- [ ] Ulcers
- [ ] Other _____

_____

_____

Preferred Pharmacy & Phone Number _____

Date of Last Physical Exam _____

Health History Form | Vivid Dental

Please indicate if you have any of the following diseases or problems.

- [ ] Do you have severe issues with coughing?
- [ ] Do you drink alcoholic beverages?
- [ ] Have there been any changes to your general health within the past year?
- [ ] Have you had a serious illness, operation or been hospitalized in the past 5 years?
- [ ] Are you taking any prescription or over-the-counter medicines?
- [ ] Are you pregnant?
- [ ] Are you taking birth control or hormone replacement?
- [ ] Are you nursing?
- [ ] Have you ever reacted adversely to any medications or injections?
- [ ] Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement.
- [ ] Do you use tobacco (smoking, chew, bidis)?
- [ ] Are you wearing a nicotine patch?
- [ ] Do you have sleep apnea?
- [ ] Have you ever taken FosaMax, Actonel or other medications containing bisphosphonates?

Please list any surgical procedures you have undergone and when they occurred.

_____

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

_____

Physician's phone number

_____

Please read the above, and understand that the information provided in this form is accurate. A truthful health history will help ensure the best possible dental treatment. The information provided here will be used by the doctor and patient to inform any further decisions of the patient's health prior to or during an appointment. By signing below you also acknowledge that you will not hold the dentist, dental practice or any other member of the practice staff responsible for any action or lack of action because of errors or omissions that may have been made during the completion of this form.

Signature: _____ Date: _____