HOLLYTREE DENTAL

Health History

Name: First, Last, Middle Initial | Preferred name

Date of Birth | Phone | Email

Address | City | State | Zip

Please list any medications you are currently taking (pills, drugs, blood thinners, contraceptive, etc.)

Are you allergic to any of the following?

☐ Anesthetic	☐ Iodine	☐ Aspirin	☐ Latex
☐ Codeine	☐ Penicillin	☐ Sulfa	☐ Ibuprofen

Are you pregnant, trying to become pregnant, or nursing?

☐ Yes ☐ No

Explain:

Any recent history of a heart attack or stroke?

☐ Yes ☐ No

Explain:

Any bisphosphonate use?

☐ Yes ☐ No

Explain:

Any use of tobacco?

☐ Yes ☐ No

Explain:

Do you have any of the following medical conditions?

☐ AIDS/HIV	☐ Congenital Heart Disorder	☐ Heart Pacemaker	☐ Renal Dialysis
☐ Anaphylaxis	☐ Convulsions	☐ Hemolphilia	☐ Rheumatic Fever
☐ Anemia	☐ Cortisone Medicine	☐ Hepatitis A	☐ Rheumatism
☐ Angina	☐ Diabetes	☐ Hepatitis B or C	☐ Scarlet Fever
☐ Arthritis	☐ Drug Addiction	☐ High Blood Pressure	☐ Sickle Cell Disease
☐ Artificial Heart Valve	☐ Easily Winded Heart	☐ Hives/Rash	☐ Sinus Trouble
☐ Asthma	☐ Emphysema	☐ Irregular Heartbeat	☐ Snoring when sleeping
☐ Autism	☐ Excessive Bleeding	☐ Joint Replacement	☐ Spina Bifida
☐ Bleeding Problems	☐ Excessive Thirst	☐ Kidney Disease/Problems	☐ Swelling of Limbs
☐ Blood Disease	☐ Fainting Spells/Dizziness	☐ Liver Disease	☐ Thyroid Disease
☐ Breathing Problems	☐ Frequent Coughs	☐ Low Blood Pressure	☐ Tuberculosis
☐ Bruising Easily	☐ Frequent Diarrhea	☐ Lung Disease	☐ Tumors
☐ Cancer	☐ Frequent Headaches	☐ Mitral Valve Prolapse	☐ Ulcers
☐ Chemotherapy/Radiation	☐ Glaucoma	☐ Pain in Jaw Joints	☐ Venereal Disease
☐ Cold Sores/Fever Blisters	☐ Heart Murmur	☐ Psychiatric Treatment	☐ Yellow Jaundice

Have you ever been hospitalized or had a major operation? Explain:

Emergency Contact | Relationship | Phone Number | Email

Signature **Date:**

Insurance Information

Policy Holder Name: **Date of Birth:** **Social:**

Employer: **Insurance Company:**

Group Number: **Member Number:** **Phone:**

Name of Previous Dentist: **Phone:**

Do we need to request X-Rays? ☐ Yes ☐ No

When was your last exam?