# HEALTH HISTORY

Physician's Name ______________________ Date of last visit ______________________

Place a mark on "yes" or "no" to indicate if you have had any of the following:

| Condition | Yes | No |
|---|---|---|
| AIDS | Yes | No |
| Anemia | Yes | No |
| Arthritis, Rheumatism | Yes | No |
| Asthma | Yes | No |
| Back Problems | Yes | No |
| Cancer | Yes | No |
| ( Metastic Bone, Breast Cancer Multiple Myeloma, Prostate, Lung) | | |
| Chemical Dependency | Yes | No |
| Chemotherapy | Yes | No |
| Circulatory Problems | Yes | No |
| Cortisone Treatments | Yes | No |
| Cough, persistent or bloody | Yes | No |
| Diabetes | Yes | No |
| Emphysema | Yes | No |
| Epilepsy | Yes | No |
| Fainting or Dizziness | Yes | No |
| Headaches | Yes | No |
| Heart Problems | Yes | No |
| Hepatitis Type ________ | Yes | No |
| Herpes | Yes | No |
| High Blood Pressure | Yes | No |
| HIV Positive | Yes | No |
| Jaundice | Yes | No |
| Kidney Disease | Yes | No |
| Liver Disease | Yes | No |
| Low Blood Pressure | Yes | No |
| Nervous Problems | Yes | No |
| Osteoporosis/Pagets | Yes | No |
| Psychiatric Care | Yes | No |
| Radiation Treatment | Yes | No |
| Respiratory Disease | Yes | No |
| Scarlet Fever | Yes | No |
| Shortness of Breath | Yes | No |
| Sinus Trouble | Yes | No |
| Skin Rash | Yes | No |
| Special Diet/Weight Loss | Yes | No |
| Stroke | Yes | No |
| Swollen Feet or Ankles | Yes | No |
| Swollen Neck Glands | Yes | No |
| Thyroid Problems | Yes | No |
| Tuberculosis | Yes | No |
| Tumors or Growths | Yes | No |
| Ulcer | Yes | No |
| Venereal Disease | Yes | No |

**Have you ever taken any of these medications?**

| Medication | Yes | No |
|---|---|---|
| Blood Thinners | Yes | No |
| Coumadin | Yes | No |
| Warfarin | Yes | No |
| Diet Medications | Yes | No |
| Adipex | Yes | No |
| Dexfenfluramine | Yes | No |
| Fastin | Yes | No |
| Fen-phen | Yes | No |
| Ionimin | Yes | No |
| Pondimin | Yes | No |
| Redux | Yes | No |
| Levoxyl | Yes | No |
| Fosamex | Yes | No |

**Have you ever had or been diagnosed with:**

| Condition | Yes | No |
|---|---|---|
| Artificial Heart Valves | Yes | No |
| Artificial Joints, Screws Pins | Yes | No |
| Bleeding abnormally, | Yes | No |
| w/extractions or surgery | Yes | No |
| Blood Disease | Yes | No |
| Congenital Heart Lesions | Yes | No |
| Heart Murmur | Yes | No |
| Hernia Repair | Yes | No |
| Mitral Valve Prolapse | Yes | No |
| Pacemaker | Yes | No |
| Rheumatic Fever | Yes | No |

**Are you allergic to:**

| Allergen | Yes | No |
|---|---|---|
| Aspirin | Yes | No |
| Barbiturates | Yes | No |
| Codeine | Yes | No |
| Ibuprofen | Yes | No |
| Latex | Yes | No |
| Local Anesthesia | Yes | No |
| Metals (i.e. gold) | Yes | No |
| Penicillin | Yes | No |
| Shellfish | Yes | No |
| Other ______________ | | |

Have you ever been hospitalized or do you have any other health concerns? Yes No

If yes, please describe ____________________________________________

**Please PRINT all medications now being taken:** ____________________________________________

____________________________________________

**Women:**

Are you pregnant? Yes No Due date ______________________

Are you nursing? Yes No Taking birth control pills? Yes No

**Authorization to Release Protected Health Information:** I understand that there may be a need to consult with other health care providers. I voluntarily authorize Dr. Leslie Ann Bouvier to use and/or disclose my Protected Health Information (PHI) related to

____________________________________________. The information will be used

Describe in detail the Protected Health Information you are authorizing to be used and/or disclosed.

and/or disclosed for the purpose of____________________________________________

Describe each purpose for which you are authorizing your Protected Health Information to be used and/or disclosed.

______________. I authorize Dr. Leslie Ann Bouvier to receive and use the information.

This authorization will end when my current treatment plan is completed or one year from the date signed below. I understand that once the information is released it may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations. I understand that I may revoke this at any time by notifying, in writing, the above-named doctor disclosing the PHI prior to their receipt or the revocation. I understand that my treatment cannot be conditioned on whether I sign this authorization. I understand that I may refuse to sign this authorization.

______________________________ ______________
Signature of Patient, Parent, Guardian or Personal Representative — Date

______________________________ ______________
Please print name of Patient, Parent, Guardian or Personal Representative — Date

# PATIENT INFORMATION

Date ____________________

SS/HIC/Patient ID # ____________________

Patient ____________________

Address ____________________

City ____________________

State ____________ Zip ____________

E-Mail ____________________

Birthdate ____________________

SS# ____________________

Sex ☐ M ☐ F Age ____________

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ____ years

Occupation ____________________

Patient Employer/School ____________________

Employer/School Address ____________________

____________________

Employer/School Phone (___) ____________________

Spouse's Name ____________________

Spouse's Employer ____________________

Whom may we thank for referring you?

____________________

# DENTAL INSURANCE

Who is responsible for this account? ____________________

Relationship to Patient ____________________

Insurance Co. ____________________

Group # ____________________

Is Patient covered by additional Insurance? ☐ Yes ☐ No

Subscriber's Name ____________________

Birthdate ____________ SS# ____________

Relationship to Patient ____________________

Insurance Co. ____________________

Group # ____________________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance

coverage with ____________________ and
Name of Insurance Company(ies)
assign directly to Dr. Leslie Ann Bouvier all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____________________
Signature of Patient, Parent, Guardian or Personal Representative

____________________
Please print name of Patient, Parent, Guardian or Personal Representative

____________ Date ____________ Relationship to Patient

# PHONE NUMBERS

Home (____) ____________ Work (____) ____________ Ext. ______ Cell (____) ____________

Spouse's Work (____) ____________ Best time and place to reach you ____________

**IN CASE OF EMERGENCY, CONTACT** (Specify someone who does not live in your household)

Name ____________________ Relationship ____________________

Home Phone (____) ____________ Work Phone (____) ____________

# DENTAL HISTORY

Reason for today's visit ____________________

____________________

Former Dentist ____________________

City/State ____________________

Have you ever had any complications following dental treatment: ☐ Yes ☐ No

If yes, please describe ____________________

____________________

Date of last dental visit ____________________

Date of last dental X-rays ____________________

Place a mark on "yes" or "no" to indicate if you have had any of the following:

| Condition | | |
|---|---|---|
| Bad Breath | Yes | No |
| Bleeding Gums | Yes | No |
| Bleeding on Lips or Mouth | Yes | No |
| Burning Sensation on Tongue | Yes | No |
| Cigarette, pipe, or cigar smoking | Yes | No |
| Clicking or popping jaw | Yes | No |
| Dry mouth | Yes | No |
| Fingernail biting | Yes | No |
| Food collection between the teeth | Yes | No |
| Grinding teeth | Yes | No |
| Gums swollen | Yes | No |
| Jaw pain or tiredness | Yes | No |
| Lip or cheek biting | Yes | No |
| Loose teeth or broken fillings | Yes | No |
| Mouth pain, brushing | Yes | No |
| Orthodontic treatment | Yes | No |
| Pain around ear | Yes | No |
| Periodontal treatment | Yes | No |
| Sensitivity to cold | Yes | No |
| Sensitivity to heat | Yes | No |
| Sensitivity to sweets | Yes | No |
| Sensitivity when biting | Yes | No |
| Sores or growths in your mouth | Yes | No |
| Tongue/lip piercing | Yes | No |

How often do you floss? ____________________

How often do you brush? ____________________