**Matthew D. Freedman D.M.D., M.A.G.D., F.A.C.D. , F.I.C.D.**
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**Lancaster, PA 17602**
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**(717) 392–8041 Fax**

Today's Date _____/_____/_____

# CONFIDENTIAL HEALTH HISTORY

Name _____ Social Security No. _____-_____-_____

Address _____ City _____ State _____ Zip _____

Birthdate ___/___/_____ Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____

If patient is a minor, Parent's name _____ SSN# _____ Email _____

Where are you employed? _____ Occupation _____

In case of emergency, whom should we contact? _____ Phone _____

1. Physician's Name _____ Phone (____) _____
   Have you had any medical care within the past two years? ..... Yes No
   Describe _____
2. Are you currently taking any medication, drugs, pills or herbal remedies, including regular doses of aspirin? ..... Yes No
   If yes, please list name and dosage _____
   _____
   _____
   _____
3. Are you addicted to, or, recovering from drugs or alcohol? ..... Yes No
4. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs? ..... Yes No
5. Are you aware of having an allergic **(or adverse)** reaction to any substance or medication? ..... Yes No
   If yes, please specify _____
6. Have you been a patient in the hospital during the past five years? ..... Yes No
7. Indicate which of the following you have had, or have at present. Circle **"yes"** or **"no"** to each item.

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Heart (surgery Disease or Attack) ... | Yes | No | Ulcers ..... | Yes | No | Hepatitis A B C (circle) ..... | Yes | No |
| Chest Pain ..... | Yes | No | Diabetes ..... | Yes | No | A.I.D.S./H.I.V. Positive ..... | Yes | No |
| Congenital Heart Disease ..... | Yes | No | Thyroid Problems ..... | Yes | No | Cold Sores/Fever Blisters ..... | Yes | No |
| Heart Murmur ..... | Yes | No | Glaucoma ..... | Yes | No | Blood Transfusion ..... | Yes | No |
| High/Low Blood Pressure ..... | Yes | No | Contact Lenses ..... | Yes | No | Hemophilia ..... | Yes | No |
| Mitral Valve Prolapse ..... | Yes | No | Emphysema ..... | Yes | No | Sickle Cell Disease ..... | Yes | No |
| Artificial Heart Valve/Pacemaker ..... | Yes | No | Chronic Cough ..... | Yes | No | Bruise Easily ..... | Yes | No |
| Rheumatic Fever ..... | Yes | No | Tuberculosis ..... | Yes | No | Liver Disease/Yellow Jaundice .... | Yes | No |
| Arthritis/ Rheumatism ..... | Yes | No | Asthma ..... | Yes | No | Neurological Disorders ..... | Yes | No |
| Cortisone Medicine ..... | Yes | No | Hay Fever/ Allergy/Hives ... | Yes | No | Epilepsy or Seizures ..... | Yes | No |
| Swollen Ankles ..... | Yes | No | Latex Sensitivity ..... | Yes | No | Fainting or Dizzy Spells ..... | Yes | No |
| Stroke ..... | Yes | No | Sinus Trouble ..... | Yes | No | Nervous/Anxious ..... | Yes | No |
| Diet (Special/Restricted) ..... | Yes | No | Radiation Therapy ..... | Yes | No | Psychiatric/ Psychological Care ... | Yes | No |
| Artificial Joints (hip, knee, etc.) ..... | Yes | No | Chemotherapy ..... | Yes | No | Injectable Drugs ..... | Yes | No |
| Kidney Trouble ..... | Yes | No | Tumors ..... | Yes | No | | | |

8. Have you lost or gained more than 10 pounds in the past year? ..... Yes No
9. Do you have or have you had any disease, condition, or problem not listed? ..... Yes No
   If yes, please list _____
10. **Women:** Are you pregnant or think you could be pregnant? Yes _____ Months No **Nursing?** Yes No
11. Do you use birth control prescriptions? Yes No

History Review

Dentist Signature _____ Date _____/_____/_____

**PLEASE TURN OVER**

Previous Dentist's Name _____

Address _____ State _____ Zip _____

Telephone (____) _____

**Date of Last Dental Visit** ____/____/____ **Last Dental Cleaning** ____/____/____ **Last Full Mouth X-rays** ____/____/____

How often do you brush your teeth? _____ How often do you floss? _____

**Do you have any dental problems now?** Yes No

If yes, please describe _____

**Are any of your teeth sensitive to:**

Hot or cold? Yes No

Sweets? Yes No

Biting or Chewing? Yes No

Have you noticed any mouth odors or bad taste? Yes No

Do you frequently get cold sores, blisters or any other oral lesions? Yes No

Do your gums bleed or hurt? Yes No

Have your parents experienced gum disease or tooth loss? Yes No

Have you noticed any loose teeth or change in your bite? Yes No

Does food tend to become caught in between your teeth? Yes No

If yes, where? _____

**Do you:**

Clench or grind your teeth while awake or asleep? Yes No

Bite your lips or cheeks regularly? Yes No

Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails) Yes No

Mouth breathe while awake or asleep? Yes No

Have tired jaws, especially in the morning? Yes No

Snore or have any other sleeping disorders? Yes No

**Smoke/chew tobacco or use other tobacco products?** Yes No

How long and what type? _____

**Have you ever had:**

Orthodontic Treatment? Yes No

Oral Surgery? Yes No

Periodontal Treatment? Yes No

Your teeth ground or the bite adjusted? Yes No

A bite plate or mouth guard? Yes No

A serious injury to the mouth or head? Yes No

If so, please describe, including cause _____

_____

**Have you experienced:**

Clicking or popping of the jaw? Yes No

Pain? (joint, ear side of face?) Yes No

Difficulty in opening or closing the mouth? Yes No

Difficulty in chewing on either side of the mouth? Yes No

Headaches, neckaches or shoulder aches? Yes No

Sore muscles (neck, shoulders)? Yes No

**Are you satisfied with your teeth's appearance?** Yes No

Would you like to keep all of your teeth all of your life? Yes No

Do you feel nervous about having dental treatment? Yes No

If so, what is your biggest concern? Yes No

_____

Have you ever had an upsetting dental experience? Yes No

What?_____ How long?_____

Have you ever been told to take a pre-medication prior to dental treatment? ..... Yes No

Is there anything else about having dental treatment that you would like us to know? ..... Yes No

If yes, please describe _____

**HIPAA Office Information**

By signing this form,I acknowledge that I am aware that this office's **Notice of Privacy Practice** is available to me at the front desk and my signature constitutes acknowledgement of such policy. I am free to ask any questions.

**Consent to Contact Consumer**

You agree, in order for us to service your account or to collect monies you may owe, Dr. Freedman and/or our agents may contact you by telephone at any number associated with your account, including wireless via number, text or email (if address was provided), which could result in charges to you. Methods of contact may include pre-recorded/artificial voice messages and/or automatic dialing device, as applicable.
I/We have read this disclosure and agree the Dr. Freedman, its employees and/or agents may contact me/us as described above.

**Consent to Treatment**

To the best of my knowledge, all preceding answers are true and correct. If anything ever changes, I will inform the Doctor at the next appointment. I am also aware there are inherent risks in all dental procedures, including administration of anesthesia (Novocaine) and the use of Nitrous Oxide (if so indicated). I give the doctor and his/her staff permission to perform dental procedures on me or my dependent or guardian. I also understand that I am free to ask questions regarding the procedure or risks involved.

Patient's Signature _____ Witness _____ Date ____/____/____

If signing for a minor, your relationship to the minor _____

If someone else is filling this form out for the patient, your name _____