Drs. HOWDY HOWDY &JONES
Cosmetic • Implant • Family Dentistry

1103 Brown Street • Washington, North Carolina 27889
Phone: 252.946.3355 • Fax: 252.948.0578

HEALTH HISTORY

Physician's Phone: _____

Name of Family Physician _____ Address _____

How is your general health? (Please Circle) Excellent Good Fair Poor

Do you have, or have you ever had, any / all of the following (Please Check)

- ☐ Heart Disease
- ☐ Stroke
- ☐ High Blood Pressure
- ☐ AIDS / HIV Positive
- ☐ Psychiatric Treatment
- ☐ Allergies
- ☐ Cardiac Pacemaker
- ☐ Diabetes
- ☐ Venereal Disease
- ☐ Blood Disorder
- ☐ Rheumatic Fever
- ☐ Arthritis
- ☐ Thyroid Disease
- ☐ Joint Replacement or Implant
- ☐ Tumor History
- ☐ Kidney Disease
- ☐ Epilepsy
- ☐ Fainting
- ☐ Asthma, Emphysema
- ☐ Radiation Treatment
- ☐ Cancer
- ☐ Liver Disorder
- ☐ Tuberculosis
- ☐ Sinus Trouble
- ☐ Heart Murmur
- ☐ Hepatitis A, B, C, D
- ☐ Ulcers
- ☐ Mitral Valve Prolapse

Have you ever been hospitalized and / or had surgery within the last five years? _____ ☐ YES ☐ NO
(If YES, please explain) _____
_____

Are you under the care of a physician now? Explain _____ ☐ YES ☐ NO
Are you taking medication, drugs or pills? (if YES, list) _____ ☐ YES ☐ NO
_____

Do you take birth control pills? _____ ☐ YES ☐ NO
Are you allergic or sensitive to penicillin or any other drugs or medicines? _____ ☐ YES ☐ NO
Explain _____
Has any doctor told you to be pre-medicated before dental treatment? _____ ☐ YES ☐ NO
Do you have any disease, condition or problem not listed above? _____ ☐ YES ☐ NO
(if YES, list) _____
Do you smoke or use tobacco products? _____ ☐ YES ☐ NO
WOMEN: Are You Pregnant? _____ Delivery Date _____

DENTAL HISTORY

Are you now in discomfort, requiring our immediate attention? _____ ☐ YES ☐ NO
Have you had regular dental checkups? _____ ☐ YES ☐ NO
When was your last dental visit? _____ What was done? _____
Do your gums bleed when brushing or flossing? _____ ☐ YES ☐ NO
Have you been told you have a gum problem? _____ ☐ YES ☐ NO
Have you lost many teeth? (if yes, please explain) _____ ☐ YES ☐ NO
Are you apprehensive about receiving any dental treatment? _____ ☐ YES ☐ NO
Have there been any complications during previous dental treatment? _____ ☐ YES ☐ NO
Do you have chronic headaches, neck or shoulder pain, or all? _____ ☐ YES ☐ NO
Do you clinch or grind your teeth while awake or during sleep? _____ ☐ YES ☐ NO
Do your jaw joints grind, pop, click, or lock open when your mouth is wide open? _____ ☐ YES ☐ NO
Do you have fluoridated water at home? _____ ☐ YES ☐ NO
Have there been any injuries to the teeth (blows, chips, etc.)? _____ ☐ YES ☐ NO
Are you dissatisfied with your teeth and their appearance? _____ ☐ YES ☐ NO
Are you deeply concerned about the finances required to return your mouth to excellent dental health? _____ ☐ YES ☐ NO
Do you want to control your dental disease and retain your teeth? _____ ☐ YES ☐ NO

_____ Date _____
Patient, Parent or Legal Guardian Please Sign Here

Updates (dates & initial) _____ _____ _____ _____ _____

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PATIENT INFORMATION

DATE: _____

PATIENT NAME _____
LAST FIRST MIDDLE

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

SOCIAL SEC. # _____ MALE / FEMALE (CIRCLE) BIRTH DATE _____

E-MAIL ADDRESS _____

EMPLOYER _____ OCCUPATION _____

MARRIED _____ SINGLE _____ DIVORCED _____ SEPARATED _____ WIDOWED _____

SPOUSE'S NAME _____

IF FULL-TIME STUDENT, NAME OF SCHOOL _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT FROM ABOVE)

NAME _____ BIRTH DATE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

RELATIONSHIP TO PATIENT _____ EMPLOYER _____

EMERGENCY INFORMATION

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU _____

COMPLETE ADDRESS _____ PHONE _____

DENTAL INSURANCE INFORMATION

NAME OF INSURED _____ SS# _____ BIRTH DATE _____

EMPLOYER _____ INSURANCE COMPANY _____

GROUP # _____ CARD ID # _____

DO YOU HAVE DUAL INSURANCE COVERAGE? YES _____ NO _____

NAME OF INSURED _____ SS# _____ BIRTH DATE _____

EMPLOYER _____ INSURANCE COMPANY _____

GROUP # _____ CARD ID # _____

ASSIGNMENT OF BENEFITS

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless arrangements have been made in advance with our office bookkeeper.

I HEREBY AUTHORIZE DRS. HOWDY, HOWDY & JONES TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO THE PHYSICIAN(S) ALL PAYMENTS FOR DENTAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

DATE _____ SIGNATURE: _____