ESTES PARK DENTAL

Daniel M. Rauk, D.D.S.

600 S. St. Vrain Ave., Suite 6 • Estes Park, Colorado 80517
970-586-9330 • Fax 970-577-0045
email: raukdds@qwestoffice.net

HEALTH HISTORY FORM

It is our goal to provide you with high quality care, assuring you long-term health and comfort.

About You

Today's Date: _____ Email Address: _____

Name: _____
Last First MI MR MRS MS DR

I prefer to be called: _____ Male Female

Birth Date: ___/___/___ AGE:____ SS# _____

Home Address: _____

_____
City State Zip

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

HM # (____) _____ CELL# (____) _____

WK # (____) _____ Ext: ____ DL # _____STATE ____

Employer: _____

Employer's Address: _____

How long there: _____ Occupation: _____

Where & When are best times to reach you? _____

Whom May We Thank For Referring You?_____

Other family members seen by us? _____

Previous / Present Dentist: _____

Last Visit Date: _____

Dental Insurance - Primary

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____)_____

Group # (Plan, Local or Policy #) _____

Insured's Name: _____ Relationship: _____

Insured's Birth date: ___/___/___ Insured SS# _____

Insured's Employer: _____

Employer's Address: _____

_____

Dental Insurance - Secondary

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____)_____

Group # (Plan, Local or Policy #) _____

Insured's Name: _____ Relationship: _____

Insured's Birth date: ___/___/___ Insured SS# _____

Insured's Employer: _____

Employer's Address: _____

_____

Spouse Information

His / Her Name:_____

Employer: _____

Work # (____) _____ Ext: ____ SS# _____

Birth Date: ___/___/___ DL # _____STATE _____

Emergency Contact

His / Her Name: _____

Relationship: _____

Work # (____) _____

Home # (____) _____

Account Responsibility

Person responsible for account: _____

Work #: (____) _____ Ext: ____ Home # (____) _____

Billing Address: _____

Relationship: _____ SS# _____

Employer: _____ DL# _____ STATE ____

Medical History

Do you have a personal physician? YES NO

Physician's Name: _____

Office # (____) _____

Date of Last Visit ____/____/____

Pharmacy _____

Medical History (continued)

Your current physical health is: GOOD FAIR POOR

Are you currently under the care of a physician? Yes No

Please explain: _____

Any hospitalization/surgeries in the last 5 years? Yes No

Nature: _____

Are you taking any prescription/over-the-counter drugs? Yes No

Please list all: _____

_____

_____

Do you smoke or use tobacco in any form? Yes No

WOMEN: are you taking *birth control pills*? Yes No

Are you Pregnant? Yes No Wk #_____

Are you nursing? Yes No

Do you currently have, or have you ever had, any of the following diseases or medical problems? (please circle Y for yes, N for No).

Y N	Acid Reflux/Gerd	Y N	Hemophilia / Abnormal Bleeding
Y N	Anemia	Y N	Hepatitis A B C
Y N	Antibiotic Pre Medication	Y N	High / Low Blood Pressure
Y N	Artificial Bones / Joints / ♥ Valves	Y N	HIV+ / AIDS
Y N	Arthritis	Y N	Kidney Problems
Y N	Asthma	Y N	Mitral Valve Prolapse
Y N	Cancer	Y N	Pacemaker / Defibrilator
Y N	Chemo / Radiation	Y N	Psychiatric Problems
Y N	Congenital Heart Disease	Y N	Rheumatic / Scarlet Fever
Y N	Dental Anxiety	Y N	Seasonal Allergies
Y N	Diabetes	Y N	Severe / Frequent Headaches
Y N	Difficulty Breathing	Y N	Shingles
Y N	Drug / Alcohol Abuse	Y N	Sickle Cell Disease / Traits
Y N	Emphysema	Y N	Sinus Problems
Y N	Epilepsy / Seizures / Fainting Spells	Y N	Stroke
Y N	Fever Blisters / Canker / Cold Sores	Y N	Thyroid Problem
Y N	Hard of Hearing / Hearing Aids	Y N	Tuberculosis (TB)
Y N	Heart Attack	Y N	Ulcers / Colitis
Y N	Heart Murmur	Y N	Other
Y N	Heart Surgery		

_____

_____

_____

Please list any serious medical condition(s) that you have ever had:

_____

_____

_____

Are you allergic to any of the following?

Y N	Aspirin	Y N	Erythromycin	Y N	Penicillin
Y N	Codeine	Y N	Jewelry/Metals	Y N	Tetracycline
Y N	Lidocaine / Epinephrine	Y N	Latex	Y N	OTHER

Please list any other drugs or materials that you are allergic to:

_____

Have you ever had a reaction to dental anesthetics? Yes No

Dental History

Why have you come to the dentist today?_____

_____

_____

Do you require antibiotics before dental treatment? Yes No

For what reason _____

Are you currently in pain? Yes No

Have you ever had a serious / difficult problem associated with previous dental work? Yes No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ/ TMD)? Yes No

Your current dental health is: Good Fair Poor

Do you like your smile? Yes No

Do your gums ever bleed? Yes No

How many times a week do you floss? ____ a day do you brush? ____

Type of bristles? Hard Medium Soft

I understand that the information I have given here today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and *it is my responsibility to inform this office of any changes in my medical status.* I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____ _____

Signature Date

Payment is due in full at the time of treatment unless prior arrangements have been approved.

THANK YOU,

for filling out this form completely.
It will enable us to help you more effectively.
If you have questions at any time, please ask us.
We are happy to help.