HEIDI TZIOROS, D.D.S.
FAMILY DENTISTRY

Health History Form

Name _____
Address:_____ City: _____
Occupation: _____
SS# _____ Emergency Contact: _____
If you are completing this form for another person, what is your relationship to that person? _____

Home Phone: _____ Business Phone: _____
State: _____ Zip Code: _____
Date of Birth: _____ Sex: M ☐ F ☐
Relationship: _____ Phone: _____
Name: _____ Relationship: _____

For the following questions, please (X) whichever applies, your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Dental Information

	Yes	No	Don't Know
Do your gums bleed when you brush?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Do you have earaches or neck pains?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Do you wear removable dental appliances?	☐	☐	☐
Have you had a serious/difficult problem associated with any previous dental treatment?	☐	☐	☐

If yes, explain: _____

How would you describe your current dental problem?
_____
Date of your last dental exam: _____
Date of last dental x-rays: _____
What was done at the time? _____
How do you feel about the appearance of your teeth?
_____
_____

Medical Information

	Yes	No	Don't Know
If you answer yes to any of the 3 items below. Please stop and return this form to the receptionist.			
Have you had any of the following diseases or problems?	☐	☐	☐
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐
Are you now under the care of a physician?	☐	☐	☐

If yes, what is/are the condition(s) being treated?
_____
_____

Date of last physical examination: _____

Physician:

Name_____ Phone _____
Address_____ City//State _____ Zip _____
Name _____ Phone _____
Address _____ City/State _____ Zip _____

	Yes	No	Don't Know
Are you taking or have you recently taken any medicine(s) including non-prescription medicine?	☐	☐	☐

If yes, which drug are you taking? _____
Prescribed: _____
_____
_____
Over the Counter:
_____
Vitamins, natural or herbal preparations and/or diet supplements:
_____
_____
_____

Are you taking, or have you taken, any diet drugs such Pondimin (fenfluramine-phentamine combination)?	☐	☐	☐
Do you drink alcoholic beverages?	☐	☐	☐

If yes, how much alcohol did you drink in the last 24 hours? _____
In the past week? _____

Are you alcohol and/or drug dependent?	☐	☐	☐

If yes, have you received treatment? Circle one Yes or No

Do you use drugs or other substances for recreational purposes?	☐	☐	☐

If yes, please list: _____
_____
Frequency of use (daily, weekly, etc.) _____
Number of years of recreational drug use:
_____

	Yes	No	Don't Know
Have you had any serious illness, operation, or been hospitalized in the past 5 years? _____	☐	☐	☐
_____			
_____			
Are you allergic to or have you had a reaction to?			
Local Anesthetics	☐	☐	☐
Aspirin	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐	☐
Sulfa drugs	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Latex	☐	☐	☐
Iodine	☐	☐	☐
Hay fever/ seasonal	☐	☐	☐
Animals	☐	☐	☐
Food (specify) _____	☐	☐	☐
Other (specify)	☐	☐	☐
Metals (Specify)	☐	☐	☐
To yes responses, specify type of reactions: _____			
_____			
_____			
_____			

	Yes	No	Don't Know
Do you use tobacco (smoking, snuff, and chew)?	☐	☐	☐
If yes, how interested are you in stopping (circle one) Very/ Somewhat/ Not Interested	☐	☐	☐
Do you wear contact lenses?			
Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
If yes, when was the operation done? _____			
_____			
If you answered yes to the above question, have you had any complication or difficulties with your prosthetic joint? _____			
_____			
Has a physician or previous dentist recommended that you take an antibiotic prior to your dental treatment?	☐	☐	☐
If yes, what antibiotic and dose? _____			
Name of physician or dentist: _____			
Phone: _____			

Women Only

Are you or could you be pregnant?	☐	☐	☐
Nursing?	☐	☐	☐
Take birth control or hormonal replacement?	☐	☐	☐

Please (X) a response to indicate. If you have or have not had any of the following diseases or problems

Abnormal Bleeding	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Anemia	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Asthma	☐	☐	☐
Blood transfusion. If yes date: _____	☐	☐	☐
Cancer/Chemotherapy/Radiation Treatment	☐	☐	☐
Cardiovascular disease. If yes, specify below:			
____ Angina ____ Heart murmur			
____ Arteriosclerosis ____High Blood Pressure			
____ Artificial heart valves ____ Low blood pressure			
____ Congenital heart defects ____ Mitral valve prolapse			
____ Congenital heart failure ____ Pacemaker			
____ Coronary artery disease ____ Rheumatic heart			
____ Damaged heart valves ____ Disease/Rheumatic fever			
____ Heart attack			
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Disease, drug, or radiation-induced immunosuppression	☐	☐	☐
Diabetes. If yes, specify:	☐	☐	☐
_____ Type 1 (Insulin dependent) _____ Type II			
Dry mouth	☐	☐	☐
Eating disorder. If yes, specify: _____	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G. E. Reflux/persistent heartburn	☐	☐	☐
Glaucoma	☐	☐	☐

Hemophilia	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Recurrent infections	☐	☐	☐
If yes, indicate type of infection: _____			
Kidney problems	☐	☐	☐
Mental health disorders, If yes, specify: _____			
Night Sweats	☐	☐	☐
Neurological disorders. If yes, specify:_____			
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Respiratory problems. If yes, specify below:	☐	☐	☐
_____ Emphysema _____ Bronchitis			
Severe headaches/migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Sinus trouble	☐	☐	☐
Sleep disorder	☐	☐	☐
Sores or ulcers in the mouth	☐	☐	☐
Stroke	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Tuberculosis	☐	☐	☐
Thyroid problems	☐	☐	☐
Ulcers	☐	☐	☐
Excessive urination	☐	☐	☐
Do you have any disease, condition or problem not listed above that you think I should know about?	☐	☐	☐
Please explain:_____			
_____			

Note: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above, I acknowledge that my questions, if any, about inquires set forth above have been answered to my satisfaction. I will not hold my dentist or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made of the competition of this form.

Signature: _____Date: _____

HEIDI TZIOROS, D.D.S.
FAMILY DENTISTRY

TMJ –Occlusal Examination

1) Have you ever been diagnosed with a problem with either jaw joint? Yes or No

2) Does you have jaw joint click, pop or makes noise when you open or close? Yes or No

3) Do you have pain or tenderness in your jaw when you open, close or chew? Yes or No

4) Has your jaw ever locked open or closed? Yes or No

5) Do you have frequent headaches? If so how often or when? Yes or No

6) Do you clench or grind your teeth or ever been told you do? Yes or No

7) Do you have a history of trauma to your chin or jaw? Yes or No

DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to patient? _____

Dental Insurance Company: _____ Group#:_____

ASSIGNEMENT AND RELEASE

I, the undersigned, certify that I (or my dependents) have insurance coverage with the dental insurance company listed above and assign directly to Dr. Tzioros all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

_____

Relationship Date