Patient Information (CONFIDENTIAL)

How did you hear about us? _____

Northwest Dental Associates can now confirm appointments by email or text. Please check your preference:

❑ Email ❑ Text ❑ Home Phone ❑ Cell Phone

Are you interested in our in-house payment program through Care Credit or Cherry Finance?

❑ Yes ❑ No

NorthwestDental ASSOCIATES

❑ Check this box if you agree to receive commercial electronic messages from Northwest Dental Associates. These messages may be related to your appointment, your health care, or the products and services we provide to our patients.

Name _____ Birthdate _____ Home Phone _____ ❑ M ❑ F

Address _____ City _____ State _____ Zip _____

Email _____ SS#_____ Cell Phone _____

If Full Time Student, Name of School/College _____ City _____ State _____

Patient or Parent/Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Emergency Contact _____ Phone _____

Responsible Party (IF SAME AS PATIENT, SKIP TO THE NEXT SECTION)

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Birthdate _____Email _____ Cell Phone _____

Employer _____ Work Phone _____ SS#_____

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

1. Have you ever been diagnosed with periodontal disease?_____

2. Have you ever been told that you snore? _____

3. Do you like your smile? _____ How would you rate your smile on a scale from 1-10? _____

4. What changes would you make to improve your smile?_____

Insurance Information (IF CARD(S) IS AVAILABLE, SKIP TO THE NEXT SECTION)

PRIMARY INSURANCE

Name of Insured _____

Relationship to Patient _____

Birthdate _____

SS#/ID# _____

Name of Employer _____

Insurance Company _____

Group # _____

Policy ID # _____

SECONDARY INSURANCE

Name of Insured _____

Relationship to Patient _____

Birthdate _____

SS#/ID# _____

Name of Employer _____

Insurance Company _____

Group # _____

Policy ID # _____

Over Please...

NorthwestDental ASSOCIATES

5200 N 91ST AVE,
OMAHA, NE 68134
(402) 572-7677

HEALTH HISTORY FORM

Patient Name: _____

Last First MI Preferred Name

Patient Medical History

Please list your Physician's name, phone number and date of your last exam.

_____

_____

Have you been hospitalized for any surgical procedure or serious illness within the last 5 years? ◯ Yes ◯ No

If yes, please explain:

_____

_____

Are you taking any medication(s) including non-prescription medicine? ◯ Yes ◯ No

If yes, what medication(s) are you taking?

_____

_____

Do you require or has your physician recommended a pre-med antibiotic prior to dental treatment? ◯ Yes ◯ No

If yes, for what reason?:

_____

_____

Do you use tobacco/ e-cigarettes? _____

Do you use controlled substances? _____

Are you taking any blood thinners? ◯ Yes ◯ No

If yes, most recent INR: _____

Are you taking any bone strengthening medications such as Prolia, Frosamax, Boniva, Fosamax, Boniva, Reclast? ◯ Yes ◯ No

Do you have or have you had Cancer? ◯ Yes ◯ No

If yes, type of cancer and treatment:

_____

_____

Do you have Diabetes? ◯ Yes ◯ No

If yes, Type and most recent A1C: _____

Have you had a Heart Attack or Stroke? ◯ Yes ◯ No

If yes, Date of Heart Attack or Stroke: _____

Do you have or have you ever had any of the following?

- ☐ *Pre-Med - Amox
- ☐ Allergies
- ☐ Allergy - Hay Fever
- ☐ Allergy - Penicillin
- ☐ Allergy - Acrylics
- ☐ Artificial Heart Val
- ☐ Cancer
- ☐ Cong. Heart Defect
- ☐ Diabetes
- ☐ GERD/Acid Reflux
- ☐ Heart Disease
- ☐ HIV/AIDS
- ☐ Kidney Disease
- ☐ Osteoporosis Meds
- ☐ Psychiatric Cond
- ☐ Sleep Apnea
- ☐ Tuberculosis
- ☐ *Pre-Med - Azithro
- ☐ Allergy - Aspirin
- ☐ Allergy - Ibuprofen
- ☐ Allergy - Sulfa
- ☐ Allergy - Food Alerg
- ☐ Asthma
- ☐ Chemotherapy
- ☐ C-PAP
- ☐ Dizziness
- ☐ Glaucoma
- ☐ Hepatitis
- ☐ HPV
- ☐ Liver Disease
- ☐ Other
- ☐ Radiation Treatment
- ☐ Stomach Problems
- ☐ Tumors
- ☐ *Pre-Med - Clind
- ☐ Allergy - Codeine
- ☐ Allergy - Latex
- ☐ Allergy - Any Metals
- ☐ Anxiety
- ☐ Blood Disease
- ☐ High/Low Cholesterol
- ☐ Dental Anxiety
- ☐ Epilepsy
- ☐ Head Injuries
- ☐ Herpes/Cold Sores
- ☐ Infect. Endocarditis
- ☐ Low Blood Pressure
- ☐ Pacemaker
- ☐ Respiratory Problems
- ☐ Stroke
- ☐ *Pre-Med - Other
- ☐ Allergy - Erythro
- ☐ Allergy - Other
- ☐ Allergy - Local Anes
- ☐ Arthritis
- ☐ Blood Thinners
- ☐ Cognitive Impairment
- ☐ Depression
- ☐ Fainting
- ☐ Hearing Impairment
- ☐ High Blood Pressure
- ☐ Joint Replacement
- ☐ Organ Transplant
- ☐ Pregnancy
- ☐ Sinus Problems
- ☐ Thyroid Problems

Women Only:

Are you pregnant or think you may be pregnant? ◯ Yes ◯ No

If yes, due date: _____

Are you nursing? ◯ Yes ◯ No

Are you taking oral contraceptives? ◯ Yes ◯ No

Notes or Other Medical Conditions (please state below):

_____

_____

I certify that the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

_____

Signature Date