Heights Family Dentistry
306 West 20th Street
Houston, Texas 77008
713-862-6408

Patient Information

Today's Date: _____

Patients Name: _____

DOB: _____ SSN: _____

Single: _____ Married: _____ Divorced: _____ Widowed: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone Number: _____

Email: _____

Emergency Contact Name: _____

Emergency Contact Phone#: _____

Insurance Information

Insurance Company: _____

Policy Holder Name & DOB: _____

Policy Holder Employer Name: _____

Member Id: _____ Group Number: _____

Relationship to Policy Holder: _____

Date: _____

Patient's Name: _____

Heights Family Dentistry
306 West 20th Street
Houston, Texas 77008
Phone: 713-862-6408 Fax: 713-862-2187

Occupation: _____

Employer: _____

Referred by: _____

UPDATED MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

	Yes	No	If yes, please list below.
Are you under a physician's care now?	☐	☐	_____
Have you ever been hospitalized/had a major operation?	☐	☐	_____
Have you ever had a serious head or neck injury?	☐	☐	_____
Have you had a joint replacement? If so, please list which joint and when.	☐	☐	_____
Have you had any heart surgeries including but not limited to stents, heart valve replacement or bypass grafts?	☐	☐	_____
Are you taking any medications, pills or drugs?	☐	☐	_____
Have you ever taken Fosamax, Boniva, Actonel, Prolia or any other medications containing bisphosphonates?	☐	☐	_____
Are you on a special diet?	☐	☐	_____
Do you use tobacco or vaping products?	☐	☐	_____
Do you use any controlled substances?	☐	☐	_____

Women: Are you ☐ Pregnant/trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?
☐ Other: _____
☐ *I do not have any allergies.*
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Latex
☐ Metal ☐ Sulfa drugs ☐ Acrylic ☐ Local anesthetics
☐ Clindamycin ☐ Food or Sodium Lauryl Sulfate (SLS) allergy: _____

Systemic Health History: please select if you had/have any of the following:

Cardiovascular
☐ Endocarditis ☐ Angina ☐ Artificial heart valve ☐ Congenital heart disorder ☐ Irregular heartbeat
☐ Heart attack/failure ☐ Heart murmur ☐ Heart pacemaker ☐ Heart disease ☐ Mitral valve prolapse

Endocrine
☐ Excessive thirst ☐ Diabetes ☐ Hypoglycemia ☐ Thyroid disease ☐ Osteoporosis
☐ Parathyroid disease

Eyes/ENT/Respiratory
☐ Asthma/wheezing ☐ Chest pain/tightness ☐ Frequent cough ☐ Sleep apnea ☐ Chronic obstructive pulmonary disorder (COPD)
☐ Glaucoma ☐ Tonsilitis ☐ Emphysema ☐ Tuberculosis

Hematology/Hepatology
☐ Anemia ☐ Bruise/bleed easily ☐ Hemophilia ☐ Sickle cell anemia
☐ Hepatitis A, B or C ☐ High blood pressure ☐ Low blood pressure ☐ Stroke

Genitourinary
☐ Frequent diarrhea ☐ Renal dialysis ☐ Ulcerative colitis ☐ Kidney problems

Muscular/Skeletal/Skin
☐ Spina bifida ☐ Swelling of limbs ☐ Hives/rash ☐ Pain in jaw joints ☐ Dry mouth
☐ Herpes/venereal disease

Psychiatric/Neurological
☐ Alzheimer's disease ☐ Anxiety/depression ☐ Psychiatric care ☐ Seizures/convulsions ☐ Tardive dyskinesia
☐ Fainting spells/dizziness ☐ Parkinson's disease

Other illnesses
☐ Shingles ☐ Scarlet fever ☐ Ulcers ☐ Hay fever ☐ Alcohol use disorder
☐ Drug use disorder ☐ Recent weight loss ☐ Use of semaglutide/ozempic

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes _____

☐ *I do not have/have not had any of the illnesses listed above.*

Contact information

Current mailing address _____

Current phone number _____

Current email address _____

Emergency contact and number _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian: _____ Date: _____