Jeffrey S. Castel, DDS, LLC
4597 Ridge Road, Brooklyn, OH 44144 (216) 398-8428

Patient Health History

Patient Name: _____ **Date of Birth:** _____

Welcome to our dental office. We are pleased you have selected our practice. Your satisfaction and quality dentistry are our top priorities. Please fill out this Health History form so we may be aware of any issues that may affect your dental care. Use the Additional Comments area on this form to include any extra information. Thank you.

Today's Date: _____ Referred by (How did you hear of our dental office?): _____
Street Address: _____
City: _____ State: _____ Zip: _____
Phone Numbers: Home: _____ Work: _____ Cell: _____
email address: _____
Spouse' Name: _____ Emergency Contact Person: _____ Their Phone Number: _____
Physician's Name: _____ Phone Number: _____ When was your last visit: _____

INSURANCE INFORMATION

Occupation: _____ Employer: _____ Employer's Phone #: _____
PRIMARY INSURANCE COMPANY: _____ Insurance Phone #: _____
Subscriber Name: _____ Subscriber SS# or ID#: _____ Subscriber Birth Date: _____
SECONDARY INSURANCE COMPANY: _____ Insurance Phone #: _____
Subscriber Name: _____ Subscriber SS# or ID#: _____ Subscriber Birth Date: _____

DENTAL HISTORY

Describe primary reason for this visit: _____

Do you have: Any sensitive, painful, chipped or broken teeth? ..... YES NO
Sinus problems? ..... YES NO
Lumps or Bumps or Swelling? ..... YES NO
Jaw pain? TMJ Disorder? ..... YES NO
Bleeding gums? ..... YES NO

Do you clench or grind your teeth? ..... YES NO
Do you wear a removable dental appliances? (Please Circle - Dentures, Retainers, or Bite Guard) ..... YES NO
Would you like WHITER TEETH? ..... YES NO
Would you like STRAIGHTER TEETH? ..... YES NO
Is there anything about your teeth you wish you could change? _____
Additional Comments _____
_____

MEDICAL HEALTH HISTORY

Do you need to be Pre-Medicated prior to dental appointments? ..... YES NO
Any serious illness, operations, hospitalizations or change in health history in the last 5 years? ..... YES NO
If yes, please explain: _____
Do you have or have you had any of the following diseases or problems?
a. Damaged heart valves, artificial valves, heart murmur or mitral valve prolapse ..... YES NO
b. Have you had an orthopedic joint replacement (knee, hip, other) ..... YES NO
c. High or Low blood pressure ..... YES NO
d. Heart trouble, heart attack, shortness of breath or any other heart condition ..... YES NO

e. Asthma ..... YES NO
f. Respiratory problems, Tuberculosis, Persistent cough or cough the produces blood ..... YES NO
g. Fainting spells, seizures, Epilepsy or Neurological Disorder ..... YES NO
h. Diabetes ..... YES NO
i. Hepatitis A, Hepatitis B, Hepatitis C, or Liver disease ..... YES NO
j. Thyroid problems ..... YES NO
k. Kidney problems ..... YES NO
l. Persistent swollen neck glands ..... YES NO
m. Cancer or treatment for a tumor or growth ..... YES NO
n. Problems of the immune system? HIV/AIDS? ..... YES NO
o. Abnormal bleeding, blood disorders (such as anemia) or blood transfusion ..... YES NO
p. Osteoporosis ..... YES NO
q. Are you taking or have you ever been prescribed **BISPHOSPHONATE MEDICATION** ..... YES NO
such as: Etidronate (Didronel), Clodronate (Bonefos, Loron), Tiludraonate (Skelid), Pamidronate (ADP, Aredia), Neridro, Olpadrinate, Alendronate (**Fosamax**), Ibandronate (**Boniva**), Risedronate (**Actonel**), Zoledronate (**Zometa**, Aclast)

Use of Tobacco Products: Never: _____ I used to use: _____ I still use: _____ I want to stop: _____

Do you have any other condition or disease? ..... YES NO

WOMEN: Are you pregnant? ..... YES NO
Are you using birth control pills or a patch? ..... YES NO

ALLERGIES: Are you allergic or have you a had a reaction to:
a. Local anesthetics (Lidocaine, Carbocaine, Articaine, Epinephrine, or Other) ..... YES NO
b. Antibiotics (ie - Penicillin, Amoxicillin, Erythromycin, Clindamycin or other antibiotic) ..... YES NO
c. Sulfa drugs ..... YES NO
d. Barbiturates or sleeping pills ..... YES NO
e. Aspirin ..... YES NO
f. Codeine or other narcotics ..... YES NO
g. Other allergies: seasonal, food, latex, plants, other _____ YES NO

List any MEDICATIONS you are taking (including non-prescriptions): _____
_____

In order for us to comply with Health Insurance Portability & Accountability Act regulations, I agree to allow this office to provide information relating to me to dental labs, dental and medical offices, companies, or others as needed in order to provide the best dental care. This dental office may confirm my appointments with another party or leave a message on my answering machine. It is okay to send out post cards and other mail to my attention. Also, I am aware that in recent light of the Coronavirus/COVID-19, this dental office follows the guidelines of the CDC, ADA, and the Ohio State Dental Board. Evenso, there is still a possible risk of contracting a virus since COVID-19 has been shown to stay in the air in aerosols for several hours after being emitted into the air.

I certify that I have read, understood and accurately answered the above information to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of the staff, responsible for any error or omissions that I may have made in the completion of this form.

X _____ _____
Signature of patient (or guardian) Date

MEDICAL HISTORY UPDATE (Use as much space as needed.)

DATE/INITIALS	UPDATES	:	DATE/INITIALS	UPDATES
_____	_____	:	_____	_____
_____	_____	:	_____	_____
_____	_____	:	_____	_____