UF Health Dentistry – Wildlight | HEALTH HISTORY QUESTIONNAIRE

Today's Date: ___________________________ **Birth Date**: _____________________________
Name: ____
LAST **FIRST** **MIDDLE INITIAL**
Address:____**Email:**____________________________
Dental Insurance: ______________________________ **Member ID:**________________________________
Reason for visit: ____________________ **How long have you had this condition?** __________________
When was your last dental visit? ____
How would you rate your health? o Excellent o Good o Fair o Poor
Are you under the care of a physician? o Yes o No **If so, why?** ______________________________
Have you ever been admitted to a hospital? o Yes o No **If so, why?** ____________________________
Have you ever had a previous operation? o Yes o No **Procedures and dates**: ____________________

(Women Only) **Are you or could you be pregnant?** o Yes o No **Are you currently nursing?** o Yes o No

HAVE YOU EVER HAD…? (PLEASE CHECK ALL THAT APPLY AND COMPLETE BACK SIDE OF PAGE)

HEART PROBLEMS	**HEAD/EYES/EARS/NOSE/THROAT PRO BLEMS**
o Hypertension	
o Heart attack/MI	o Frequent Headaches
o Angina/Chest Pain	o Jaw Joint/TMJ Popping, Catching, or Pain
o Prosthetic Heart Valve	o Glaucoma
o Congestive Heart Failure	o Sinus/Nasal Problems
o Heart Bypass/Stent Surgery	**DIGESTIVE PROBLEMS**
o Congenital Heart Failure	o Hepatitis/Jaundice
o Pacemaker/Defibrillator	o Liver Disease
o Infective Endocarditis	o GERD/Reflux/Ulcers
o Heart Palpitations	**ENDOCRINE PROBLEMS**
o Irregular Heartbeat	o Diabetes (o Type 1 o Type 2)
o Rheumatic Fever	o Thyroid Disorders
o Rheumatic Heart Disease	**NERVOUS SYSTEM PROBLEMS**
BREATHING PROBLEMS	o Stroke/TIA/Mini-Stroke
o Asthma	o Epilepsy/Seizure Disorder
o Tuberculosis	o Neuropathy
o Sleep Apnea	**PSYCHIATRIC PROBLEMS**
o Bronchitis/Emphysema/COPD	o Depression
o Cough	o Panic/Anxiety Disorder
o Shortness of Breath	o Other Psychiatric/Emotional Disorder
o Pneumonia	Please Specify: _______________________________
BLOOD PROBLEMS	**OTHER PROBLEMS**
o Anemia	o Renal/Kidney/Prostate Disease
o Sickle Cell Disease	o Organ Transplant (Specify: _________________)
o HIV/AIDS	o Cancer/Tumors (Specify: __________________)
o Bleeding Disorders (e.g. Hemophilia, Coumadin)	o Radio therapy/Chemotherapy
o Warfarin Treatment	o Arthritis
o Bruising Easily	o Joint Replacement (Specify: ________________)
	o Other (Specify: ___________________________) **(PLEASE TURN PAGE OVER)**

UFHealth
UNIVERSITY OF FLORIDA HEALTH

FAMILY HISTORY OF:	**DO YOU TAKE ANY OF THE FOLLOWING:**
o Cancer	o Anticoagulants (Blood Thinners)
o Arthritis	o Aspirin
o Heart Disease	o Coumadin
o Hypertension	o Plavix
o Anesthesia Complications	o Bisphosphonates (Reclast/Fosamax/Boniva/Aredia/Zometa)
ARE YOU ALLERGIC TO:	o Steroids
	o Birth Control Pills
o Aspirin	o Other Medicines/Supplements (List Below):
o Iodine	
o Pain Medication	
o Penicillin/Amoxicillin	
o Other Antibiotics (Specify: _________________)	
o Latex	
o Environmental/Seasonal Allergies	
o Other Allergies	
Please Specify: ______________________________	
HAVE YOU EVER USED:	
o Tobacco	
o Alcohol	
o Recreational/Street Drugs	

Patient Signature :

Guardian Signature:

Date:

UF Health Dentistry – Wildlight | PATIENT PREFERENCES

Patient: ____ Date: ___________________________________

Briefly tell us how you feel about your teeth, your smile, and your dental expectations.

1. What are your expectations from this office?
   ____
   ____
   ____

2. Would you like to learn how you can have all of your teeth for the rest of your life? ❑ yes ❑ no

3. If you are already missing some teeth, would you like to learn how you can avoid having full dentures? ❑ yes ❑ no

4. Do you like your smile? ❑ yes ❑ no

5. If the answer is no, what don't you like and what changes would you like to see?
   ____
   ____
   ____

6. If you feel that your teeth have yellowed, or are not white enough, would you like to learn about tooth whitening? ❑ yes ❑ no

7. Are you interested in an overall cosmetic dental evaluation? ❑ yes ❑ no

8. If you are contemplating a dental cosmetic change, what is most important to you?
   ____
   ____

9. Are you aware of anything that might prevent you from having basic or cosmetic dental treatment? ❑ yes ❑ no

10. Have all of your past dental office experiences been positive? ❑ yes ❑ no
    If not, please explain:
    ____
    ____

11. Is there anything in particular that you would like us to always do for you? ❑ yes ❑ no
    If yes, please explain:
    ____
    ____

12. Is there anything in particular that you would like us never to do? ❑ yes ❑ no
    If yes, please explain:
    ____
    ____

13. Do you have any dental concerns not listed that you would like to bring to our attention? ❑ yes ❑ no
    If yes, please explain:
    ____
    ____

Thank you for taking the time to complete this form!

UF | UNIVERSITY of FLORIDA

College of Dentistry
Wildlight Clinic

76011 William Burgess Blvd
Yulee, FL 32097
904-427-8587
904-427-8591 Fax

No Show Policy

We schedule our appointments so that each patient receives the right amount of time to be seen by our dentist. That is why it is very important that you keep your scheduled appointment with us, and arrive on time.

As a courtesy, and to help patients remember their scheduled appointments, we call and send a text message 4 days, 2 days, and 1 day in advance of your appointment time.

If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you, and accommodate those patients who are waiting for an appointment. As a courtesy to our office, as well as to those patients who are waiting to schedule with the dentist, please give us at least a 24-hour notice.

If you do not cancel or reschedule your appointment with at least 24 hours' notice, we may assess a $50.00 "no-show" service charge to your account. This no-show fee is not reimbursable by your insurance company. You will be billed for it directly.

After three consecutive no-shows to your appointment, our practice may decide to terminate its relationship with you.

I understand the "no-show" policy of UF Health Dentistry – Wildlight. I understand that I must cancel or reschedule any appointment at least 24 hours in advance in order to avoid a potential no-show charge.

____________________________________ _______________________________________

Signature **Date**