PATIENT HEALTH RECORD

In order to help us provide the proper dental services to you, please answer the following questions. Please use the space for remarks or clarification which would be helpful to us. Thank you.

Please fill in completely

Date _____ Referred by _____

PATIENT _____ Age _____ Birthdate _____
Mailing Address _____ Phone _____
Residence Address _____ Business Phone _____
Social Security # _____ Spouse or Parent _____

RESPONSIBLE PARTY _____ Relation to Patient _____
Address _____ Birthdate _____
Email Address _____ Policy # _____
Insurance Company _____ Guarantor's Social Security # _____
Driver's License # _____ Employed By _____
Address _____ How Long? _____
Business Phone _____

MEDICAL HEALTH

Is your visit for relief of pain? ..... yes ( ) no ( )
If yes, where is the pain and how long have you had it? _____
Name and address of physician _____
Are you being treated or have you been treated within the last year by a physician? _____
List medications you are taking now _____
General Health: Excellent ( ) Good ( ) Fair ( ) Poor ( )
Are you allergic or had a reaction to: Penicillin ( ) Latex or rubber ( ) Codeine or other narcotics ( )
Local Anesthetics ( ) Aspirin ( ) Metals ( ) Other ( ) _____

HAVE YOU BEEN TREATED FOR:

	yes	no		yes	no
Heart Disease	( )	( )	**Heart murmur, damaged heart valves**	( )	( )
Rheumatic fever	( )	( )	**Hepatitis, Jaundice, Liver disease**	( )	( )
Prosthetic joints	( )	( )	**AIDS or HIV infection**	( )	( )
Date of Surgery _____			Are you subject to prolonged bleeding?	( )	( )
Abnormal Blood Pressure	( )	( )	Asthma, hay fever, sinus trouble	( )	( )
Tuberculosis or lung disease	( )	( )	Epilepsy or neuralgic disease	( )	( )
Diabetes	( )	( )	Arthritis or painful swollen joints	( )	( )
Glaucoma	( )	( )	Respiratory problems, emphysema, bronchitis	( )	( )
Cancer	( )	( )	Fainting spells	( )	( )
Are you currently undergoing cancer treatment	( )	( )	Ulcers or hyperacidity	( )	( )
Persistent cough/produces blood	( )	( )	History of substance abuse	( )	( )
Kidney problems	( )	( )	Have you had eye trouble recently?	( )	( )
Anemia	( )	( )	Do you smoke/chew tobacco?	( )	( )

Does your mouth feel dry or do you have a burning sensation of lips or tongue? ..... ( ) ( )
Have you taken or been given injections of steroids such as cortisone? ..... ( ) ( )
Following injuries or dental treatment, have you ever had bleeding problems? ..... ( ) ( )
Have you ever had an unusual reaction to dental anesthesia (shots or gas)? ..... ( ) ( )

WOMEN

Are you pregnant? ..... ( ) ( ) How Long? _____
Are you nursing? ..... ( ) ( ) Are you taking birth control pills? ..... ( ) ( )

(see other side)

DENTAL HEALTH

When was your last dental visit? _____

Have you ever had any significant problem with past dental treatment? _____

Have you been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? _____

Has a dentist or hygienist shown you how to clean your teeth? ( ) yes ( ) no

If "yes" do you use this method? _____

Do you have sores, swellings or blisters on your gums, cheeks, tongue or lips? ( ) yes ( ) no

Have you had orthodontic treatment to straighten your teeth? ( ) yes ( ) no

Do you have pain in or near your ears? ( ) yes ( ) no

Do you wake up with headaches? ( ) yes ( ) no

Do you ever have ringing in your ears? ( ) yes ( ) no

Do you clench or grind your teeth during day/night? ( ) yes ( ) no

Please check any items that you use daily in mouth care:

( ) Hand toothbrush ( ) Electric toothbrush

( ) Dental floss ( ) Gum stimulators, toothpicks

( ) Rubber tip ( ) Oral irrigator, water pik

( ) Other _____

How often do you brush your teeth? _____

Do you use a fluoride toothpaste? ( ) yes ( ) no

What texture toothbrush do you use? _____

Do your gums bleed when brushing or flossing? ( ) yes ( ) no

Do your gums feel tender or swollen? ( ) yes ( ) no

Do you avoid brushing any part of your gums because of pain? ( ) yes ( ) no

Do you feel twinges of pain when your teeth come in contact with:

a) hot foods or liquids ( ) yes ( ) no

b) cold foods of liquids ( ) yes ( ) no

c) sweets ( ) yes ( ) no

d) sours ( ) yes ( ) no

Are any of your teeth sensitive when you brush or floss them? ( ) yes ( ) no

Do you chew on only one side of your mouth? ( ) yes ( ) no

Do your jaws ever feel tired or ache? ( ) yes ( ) no

Do you wear dentures or removable dental appliance? ( ) yes ( ) no

Do you usually have many cavities? ( ) yes ( ) no

Do you lose fillings or break fillings? ( ) yes ( ) no

Do you gag easily? ( ) yes ( ) no

Are you familiar with the term "preventive dentistry"? ( ) yes ( ) no

CHILDREN

Have they taken fluoride? If yes, at what age? _____ ( ) yes ( ) no

Have they had any problems when going to the dentist or doctor? ( ) yes ( ) no

Do you know how to brush their teeth? ( ) yes ( ) no

Do you have any questions about fluoride, baby bottle syndrome, plastic seals or anything else for the hygienist or dentist? ( ) yes ( ) no

Please add anything you feel is important or you would like to share.

_____

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PAYMENT IS EXPECTED AT THE TIME OF YOUR APPOINTMENT UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE.

_____

Patient Signature