PATIENT HEALTH RECORD

THE FOLLOWING INFORMATION IS REQUESTED TO ASSIST THE DOCTOR IN ADMINISTERING THE PROPER DENTAL SERVICE. PLEASE ANSWER THE QUESTIONS TO THE BEST OF YOUR ABILITY, AND USE THE ADDITIONAL SPACE FOR ANSWERS REQUIRING CLARIFICATION OR ANY ADDITIONAL INFORMATION.
THANK YOU FOR YOUR COOPERATION.

DATE_____ CELL #_____

NAME (LAST)_____(FIRST)_____(MIDDLE)_____

HOME ADDRESS_____CITY_____STATE_____ZIP_____

EMPLOYER NAME_____

EMPLOYER ADDRESS_____CITY_____STATE_____ZIP_____

HOME PHONE_____ WORK PHONE_____

E-MAIL ADDRESS_____

OCCUPATION_____ DATE OF BIRTH_____

SEX M / F HEIGHT_____FT._____IN. WEIGHT_____

MARITAL STATUS (CIRCLE) SINGLE MARRIED WIDOWED DIVORCED

SOCIAL SECURITY NO._____

DRIVER'S LICENSE NO._____

DENTAL INS. NAME_____ INSURED NAME_____

GROUP NO._____ INS. PHONE_____

INSURED EMPLOYER'S NAME, ADDRESS, PHONE & SOC. SEC.# (IF NOT PATIENT)

_____

_____

SPOUSE'S NAME_____

PARENT'S NAME(IF CHILD)_____

REFERRED BY_____

REASON FOR YOUR VISIT_____

EMERGENCY INFORMATION - NAME, ADDRESS AND TELEPHONE NO. OF AN INDIVIDUAL WE CAN CALL.

_____

_____

_____

PLEASE NOTE: The patient is responsible for payment at the time of service and/or for any outstanding balance on their account irregardless of insurance coverage. We will make every effort to assist you in order that you may receive insurance imbursement. Patient/Parent is responsible for any and all collection costs or attorney's fees resulting in failure to mail payment when due.

MEDICAL HEALTH

General health (please check): Excellent___ Good____ Fair____ Poor____
Name, address and telephone number of your physician_____

_____

Last complete physical? _____
Are you presently under the care of a physician? . . . Yes___ No____
If so, for what reason?_____

_____

_____

Are you taking any medication now? Yes ____ No____ _____

_____

If yes, please list all medications._____

_____

_____

Are you allergic to: Antibiotics_____ Codeine_____ Aspirin_____
Local Anesthetics_____ or any other medications?_____

Have you ever been hospitalized? If so give name of hospital, reason and dates.

_____

_____

Have you had any radiological diagnostic x-rays in the last 5 years?. . . .Yes___ No___
When?_____

Have you had any blood transfusions? . . . . . Yes___ No___

Are you currently trying to modify your weight? . . . . . Yes___ No___

Do you take any medications to help in weight reduction? . . . . . Yes___ No____

Do you use any tobacco products? . .Yes___ No___ Amount per day? _____

Do you consume alcohol on a daily basis? . . . . . Yes___ No___

Is your blood pressure Normal_____ Low____ High____?

Have you experienced any recent weight change? . . . . . Yes___ No___

Women: Are you pregnant? Yes___ No___ How Long?_____
Do you experience pre-menstrual syndrome? . . . . . Yes___ No___

DO YOU HAVE OR HAVE YOU EVER BEEN INFORMED THAT YOU HAD ANY OF THE FOLLOWING?

CHEST PAINS . . . . . Yes___ No___
HEART DISEASE . . . . . Yes___ No___
RHEUMATIC FEVER . . . . . Yes___ No___
CONGENITAL HEART DEFECTS . . . . . Yes___ No___
HEART MURMUR . . . . . Yes___ No___
POSTURAL HYPERTENSION (FAINTING SPELLS) . . . . . Yes___ No___
HYPERTENSION . . . . . Yes___ No___
KIDNEY PROBLEMS . . . . . Yes___ No___
STROKE . . . . . Yes___ No___
THYROID PROBLEMS . . . . . Yes___ No___
HORMONAL PROBLEMS . . . . . Yes___ No___
ULCERS . . . . . Yes___ No___
TUBERCULOSIS OR LUNG DISEASE . . . . . Yes___ No___
DIABETES . . . . . Yes___ No___
EPILEPSY OR SEIZURES . . . . . Yes___ No___
ANEMIA . . . . . Yes___ No___
CANCER OR LEUKEMIA . . . . . Yes___ No___
PSYCHIATRIC PROBLEMS . . . . . Yes___ No___
SICKLE CELL DISEASE . . . . . Yes___ No___
GLAUCOMA . . . . . Yes___ No___
PROSTHETIC VALVES OR JOINTS . . . . . Yes___ No___
BRUISE EASILY . . . . . Yes___ No___
JAUNDICE . . . . . Yes___ No___
ASTHMA OR HAY FEVER . . . . . Yes___ No___
ALLERGIES OR HIVES . . . . . Yes___ No___
SINUS TROUBLE . . . . . Yes___ No___
ARTHRITIS . . . . . Yes___ No___
EXCESSIVE URINATION AND/OR THIRST . . . . . Yes___ No___
PERSISTENT COUGH . . . . . Yes___ No___
PROLONGED BLEEDING PROBLEMS . . . . . Yes___ No___
SEXUALLY TRANSMITTED DISEASES
(GONORRHEA, SYPHILIS, GENITAL HERPES) . . . . . Yes___ No___
GENETIC PROBLEMS . . . . . Yes___ No___
SKIN DISEASE . . . . . Yes___ No___
AIDS . . . . . Yes___ No___
UNEXPLAINED FEVERS . . . . . Yes___ No___
PROLONGED SORE THROAT . . . . . Yes___ No___
ENLARGED LYMPH NODES . . . . . Yes___ No___
NIGHT SWEATS . . . . . Yes___ No___
PERSISTENT DIARRHEA . . . . . Yes___ No___
BLUISH-REDDISH LESIONS . . . . . Yes___ No___
FATIGUE . . . . . Yes___ No___

Have you ever been tested for Hepatitis? . . . . . Yes___ No___
Do you have a history of cold sores, fever blisters,
or canker sores? . . . . . Yes___ No___
Are you being treated with immunosuppressive drugs? . . . . . Yes___ No___
Have you ever used drugs for recreational purposes? . . . . . Yes___ No___

DENTAL HEALTH

When was your last dental visit?_____
Have you ever had any serious problems associated with previous dental
treatment? Yes___ No___ If yes, explain:_____
How often do you brush your teeth?_____
How often do you floss?_____
Do you routinely use a mouth rinse? Yes___ No___ How often?_____
Do you experience dry mouth (Xerostomia)? . . . . . Yes___ No___
Do your gums feel tender or swollen? . . . . . Yes___ No___
Do your gums bleed while brushing and/or flossing? . . . . . Yes___ No___
Do you avoid brushing any part of your mouth because
of pain or sensitivity? . . . . . Yes___ No___
Do you feel twinges of pain when your teeth come in
contact with hot, cold, sweet or sour? . . . . . Yes___ No___
Are you any of your teeth sensitive to air or during chewing? . . . . . Yes___ No___
What texture brush do you use? Soft___ Medium___ Hard___
Do you chew on only one side of your mouth? . . . . . Yes___ No___
Does food catch between your teeth? . . . . . Yes___ No___
Do you feel your teeth are affecting your health in any way? . . . . . Yes___ No___
Have you ever had profession advice in dental home care? . . . . . Yes___ No___
Do you clench or grind your your teeth while sleeping
or during the day? . . . . . Yes___ No___
Do your facial muscles ever feel tired? . . . . . Yes___ No___
Do you wear full dentures? Upper___Lower___ . . . . . Yes___ No___
Do you wear partial dentures? Upper___Lower___ . . . . . Yes___ No___
Do you have retention problems with your full or partial dentures? . . . . . Yes___No___
Do you gag easily? . . . . . Yes___ No___
Are you apprehensive (nervous) about your dental treatment? . . . . . Yes___ No___
If yes, have you had:
Nitrous Oxide____ Medication prior to treatment ____
Please add anything you feel is important:
_____
_____
_____

CONSENT

The undersigned hereby authorizes the Doctor to perform all the necessary diagnostic procedures deemed appropriate to make a thorough diagnosis of the patient's dental or oral-facial needs including x-rays, study models, photographs, medications, and the use of local anesthetic agents.

_____
Patient Signature (Parent of child) **Date**

_____
Dentist Signature **Date**