PATIENT INFORMATION AND HEALTH RECORD

Name_____ Date of Birth_____ ❑ Male ❑ Female
(Last) (First) (Middle)

Address_____ Cell Phone_____
(Street)

_____ Home Phone_____
(City) (State) (Zip)

_____
(Occupation) (Employer) (Address) (Phone)

Spouse's Name_____

_____
(Occupation) (Employer) (Address) (Phone)

(If child, please list parent's names and each of their occupations, employer address and phone.)

Father_____

Mother_____

Person Responsible for account_____
(Name) (Phone)

_____
(Address) (Relationship to patient)

Do you have dental insurance? ❑ Yes ❑ No

If yes, please fill out insurance information sheet. *(See attached)*

Who may we thank for referring you to our office?_____

Name of relative & phone number in case of emergency:_____
(other than spouse and relative to patient)

MEDICAL HISTORY

Name of physician:_____

Date of last complete physical:_____

Hospitalized or had surgery within last 2 years? ❑ Yes ❑ No If so, what?_____

Have you ever had joint replacement? ❑ Yes ❑ No If so, when?_____

Do you have abnormal blood pressure? ❑ High ❑ Low ❑ No

Are you taking any medications or supplements? ❑ Yes ❑ No

If so, what are you taking?_____

_____

Do you have any allergies? ❑ Penicillin ❑ Codeine ❑ Local Anesthetics ❑ Latex ❑ Other:_____

Do you smoke? If so, how much?_____

Women: Are you pregnant/trying to get pregnant? ❑ Yes ❑ No Taking oral contraceptives? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No

Have you ever had or have any of the following conditions? *(Check all that apply)*

Heart Disease . . . . . ❑ Yes ❑ No
Rheumatic Fever . . . . . ❑ Yes ❑ No
Tuberculosis or Lung Disease . . . . . ❑ Yes ❑ No
Diabetes . . . . . ❑ Yes ❑ No
Epilepsy . . . . . ❑ Yes ❑ No
Convulsions . . . . . ❑ Yes ❑ No
Anemia . . . . . ❑ Yes ❑ No
Angina . . . . . ❑ Yes ❑ No
Congenital Heart Lesions . . . . . ❑ Yes ❑ No
Arthritis . . . . . ❑ Yes ❑ No
AIDS/HIV . . . . . ❑ Yes ❑ No

Mitral Valve Prolapse . . . . . ❑ Yes ❑ No
Heart Murmur . . . . . ❑ Yes ❑ No
Jaundice . . . . . ❑ Yes ❑ No
Kidney Disease . . . . . ❑ Yes ❑ No
Liver Disease . . . . . ❑ Yes ❑ No
Pacemaker . . . . . ❑ Yes ❑ No
Organ Transplant . . . . . ❑ Yes ❑ No
Psychiatric Treatment . . . . . ❑ Yes ❑ No
Sickle Cell Anemia . . . . . ❑ Yes ❑ No
Thyroid Disease . . . . . ❑ Yes ❑ No
Sexually Transmitted Disease . . . . . ❑ Yes ❑ No

(OVER)

Drug Dependence . . . . . ❑ Yes ❑ No
Prolonged Bleeding . . . . . ❑ Yes ❑ No
Herpes . . . . . ❑ Yes ❑ No
Cancer . . . . . ❑ Yes ❑ No
Chemotherapy . . . . . ❑ Yes ❑ No
Radiation . . . . . ❑ Yes ❑ No

Asthma . . . . . ❑ Yes ❑ No
Sinus Troubles . . . . . ❑ Yes ❑ No
Hepatitis . . . . . ❑ Yes ❑ No
Glaucoma . . . . . ❑ Yes ❑ No
Stroke . . . . . ❑ Yes ❑ No
Fainting Spells . . . . . ❑ Yes ❑ No

If you checked yes to any of the diseases or conditions in the list, please explain:_____

_____

DENTAL HISTORY

Reason for present dental visit:_____

Any problems requiring immediate attention?_____

Date of last dental visit:_____

Any serious problems with prior dental treatment? ❑ Yes ❑ No If so, what?_____

Do your gums bleed when you brush? ❑ Yes ❑ No Do your gums feel swollen or tender? ❑ Yes ❑ No

Have you had a periodontal treatment? ❑ Yes ❑ No If so, when?_____

Do you feel twinges of pain with hot foods or liquids? ❑ Yes ❑ No Cold foods or liquids? ❑ Yes ❑ No Sweets? ❑ Yes ❑ No

Do you clench or grind your teeth? ❑ Yes ❑ No Do your jaws ever feel tired or ache? ❑ Yes ❑ No

Have you ever had orthodontic treatment? ❑ Yes ❑ No If so, when?_____ Do you have any loose teeth? ❑ Yes ❑ No

Do you have any cracked or broken teeth? ❑ Yes ❑ No Do you have any missing teeth? ❑ Yes ❑ No

Have they been replaced? ❑ Yes ❑ No If so, by what treatment?_____

Are you happy with this treatment? ❑ Yes ❑ No How do you feel about the appearance of your smile?_____

Have you ever had a cosmetic dental procedure to improve your smile? ❑ Yes ❑ No Are you happy with the result? ❑ Yes ❑ No

Have you ever had nitrous oxide or "gas" for previous dental treatment? ❑ Yes ❑ No

Have you had an unpleasant dental experience? ❑ Yes ❑ No

Please add anything else that you feel is important or would make your visit more positive:_____

_____

Signature, Patient's or if Child, Parent's Signature Date Dr.'s Signature

Signatures give us consent for treatment

**** Office Use Only ****

HEALTH HISTORY UPDATES

Date:_____ ❑ No Changes ❑ Yes:_____

Date:_____ ❑ No Changes ❑ Yes:_____

Date:_____ ❑ No Changes ❑ Yes:_____

Date:_____ ❑ No Changes ❑ Yes:_____

Date:_____ ❑ No Changes ❑ Yes:_____

Date:_____ ❑ No Changes ❑ Yes:_____

Date:_____ ❑ No Changes ❑ Yes:_____

Date:_____ ❑ No Changes ❑ Yes:_____

Date:_____ ❑ No Changes ❑ Yes:_____

Date:_____ ❑ No Changes ❑ Yes:_____

Date:_____ ❑ No Changes ❑ Yes:_____

Date:_____ ❑ No Changes ❑ Yes:_____