Patient Health Record

Patient Information

Date _____

Name _____ Social Security No. _____
(last) (first) (middle)

Date of Birth _____ Sex M F Height _____ Weight _____

Please check the number below which is best to reach you/leave a message regarding dental appointments.

Home Address _____ ❑ Home Phone _____
(street) (city/state) (zip)

Business Address _____ ❑ Business Phone _____
(street) (city/state) (zip)

Occupation _____ Employer _____ ❑ Cell Phone _____

Marital Status _____ Spouse/Partner's Name _____ Email _____

Name of Dental Insurance (if applicable) _____ Certificate # _____ Group # _____

Referred By _____ Previous Dentist _____

If you are completing this form for another person, what is your name and relationship to that person? _____

In case of an emergency, please provide a name and phone number for an emergency contact _____

Medical Health History

For the following questions please check "Y" for yes or "N" for no. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire, and there may be additional questions concerning your health.

Name and address of your physician _____

Are you in good health? .....Y ❑ N ❑ Date of last physical examination _____

Have you ever been a patient in a hospital or under the care of a physician during the past 5 years? ..... Y ❑ N ❑

If yes, please explain _____

Have you had any other serious illnesses, operations or hospitalizations in the past?..... Y ❑ N ❑

If yes, please explain _____

Do you currently smoke? .....Y ❑ N ❑ If yes, for how long? _____ How much per day? _____

Have you ever smoked?.....Y ❑ N ❑ If yes, for how long? _____ When did you stop smoking? _____

Do you chew tobacco? .....Y ❑ N ❑ If yes, for how long? _____ How much per day? _____

Have you ever chewed tobacco? ....Y ❑ N ❑ If yes, for how long? _____ When did you stop chewing? _____

Do you drink alcoholic beverages? ....Y ❑ N ❑ What type? _____ Frequency of use _____

Are you allergic to or have you had an adverse reaction to (please check)?

Penicillin or other antibiotics ❑ Codeine or other pain killers ❑ Local Anesthesia (Novacaine, etc.) ❑ Latex/Rubber ❑

Sedatives/Barbiturates ❑ Aspirins/Ibuprofen ❑ Foods/Dye ❑ Other allergic concerns/items ❑

Please list _____

Are you using any of the following medications (please check)?

Antibiotics ❑ Anticoagulants (Blood Thinners) ❑ Aspirin (or drugs such as Motrin, Aleve, Ibuprofen, etc.) ❑

Fosamax® or similar ❑ High Blood Pressure Medication ❑ Steroids (Cortisone, etc.) ❑ Tranquilizers ❑

Insulin/Oral Diabetic Medication ❑ Heart Medication (Digitalis, Inderal, Nitroglycerin, etc.) ❑

Other medicine(s) (including non-prescription medicine(s) ❑

Please list medicine(s) you are currently taking _____

If you are taking Coumadin (Warfarin), please complete the following:

Physician managing blood thinner(s) _____

Are you taking any of the following herbal remedies (please check)?

Echinacea ❑ Ginkgo biloba ❑ Garlic ❑ Ginseng ❑ Other herbal remedies/vitamins ❑

Please list _____

Do you have or have you had (please check "Y" for yes or "N" for no)?

Previous or current use of intravenous (IV) bisphosphonates such as Aredia® or Zometa® ..... Y ❑ N ❑
Rheumatic fever/Rheumatic heart disease ..... Y ❑ N ❑
Congenital heart disease ..... Y ❑ N ❑
- Serious congenital heart condition(s) (present since birth) ..... Y ❑ N ❑
- Unrepaired cyanotic congenital heart disease (including those with shunts) ..... Y ❑ N ❑
- Completely repaired congenital heart disease ... Y ❑ N ❑
  Date of treatment _____
- Repaired congenital heart disease with residual defect ..... Y ❑ N ❑

Infective bacterial endocaritis history ..... Y ❑ N ❑
Cardiovascular disease ..... Y ❑ N ❑
- Heart attack ..... Y ❑ N ❑
- Heart murmur ..... Y ❑ N ❑
- Coronary artery disease ..... Y ❑ N ❑
- Angina ..... Y ❑ N ❑
- High blood pressure ..... Y ❑ N ❑
- Stroke ..... Y ❑ N ❑
- Palpitations ..... Y ❑ N ❑
- Heart surgery ..... Y ❑ N ❑
- Pacemaker ..... Y ❑ N ❑
- Artificial (prosthetic) heart valve(s) ..... Y ❑ N ❑
- Heart transplant ..... Y ❑ N ❑

Lung disease/Breathing concerns ..... Y ❑ N ❑
- Asthma ..... Y ❑ N ❑
- Emphysema ..... Y ❑ N ❑
- Chronic cough ..... Y ❑ N ❑
- Tuberculosis ..... Y ❑ N ❑
- Shortness of breath ..... Y ❑ N ❑
- Sinus/Nasal problems ..... Y ❑ N ❑
- Chest pain ..... Y ❑ N ❑

Neurologic concerns ..... Y ❑ N ❑
- Seizures/ Convulsions ..... Y ❑ N ❑
- Epilepsy ..... Y ❑ N ❑
- Fainting/Dizziness ..... Y ❑ N ❑

Psychiatric treatment ..... Y ❑ N ❑
Bleeding disorder/concerns ..... Y ❑ N ❑
- Anemia ..... Y ❑ N ❑
- Bleeding tendency ..... Y ❑ N ❑
- Blood transfusion ..... Y ❑ N ❑
- Bruise easily ..... Y ❑ N ❑

Liver disease (jaundice, hepatitis) ..... Y ❑ N ❑
Kidney disease ..... Y ❑ N ❑
Diabetes ..... Y ❑ N ❑
Thyroid disease ..... Y ❑ N ❑
Arthritis ..... Y ❑ N ❑
Stomach ulcers or colitis ..... Y ❑ N ❑
Glaucoma ..... Y ❑ N ❑
Implants/Prosthetic joint placed anywhere in your body (heart valve, knee, hip) ..... Y ❑ N ❑
Cancer ..... Y ❑ N ❑
- Type _____ Date _____
- Radiation (xray) treatment or chemotherapy ..... Y ❑ N ❑
- Pertinent Info _____

HIV, AIDS or ARC ..... Y ❑ N ❑
Any disease, drug or transplant operation that has depressed your immune system? ..... Y ❑ N ❑
Do you have any other disease, condition or problem not listed above that you think the doctor should know about? ..... Y ❑ N ❑
Do you wish to speak privately to the doctor about anything? ..... Y ❑ N ❑

Women Only

Are you pregnant or any chance you might be pregnant? ..... Y ❑ N ❑
If yes, how many months? _____ How many weeks? _____
Are you nursing? ..... Y ❑ N ❑
Are you taking birth control pills? ..... Y ❑ N ❑

If you are using oral contraceptives, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

Dental Health

Reason for visit _____

When was your last dental visit? _____ What was done? _____

Have you ever had any serious problem associated with previous dental treatment? ..... Y ❑ N ❑

If yes, explain _____

How often do you brush your teeth? _____ How often do you floss? _____

Do you use a rubber tip? ..... Y ❑ N ❑

Do you use a proxy brush? ..... Y ❑ N ❑

Do your gums bleed while brushing or flossing? ..... Y ❑ N ❑

Do your gums feel tender or swollen? ..... Y ❑ N ❑

Have you ever been told you have gum disease? ..... Y ❑ N ❑

Do you avoid brushing any part of your mouth or are you eating on one side because of pain? ..... Y ❑ N ❑

If yes, what part/side? _____

Do you feel a sharp or dull pain when your teeth come in contact with:

a) hot foods or liquids? ..... Y ❑ N ❑ If yes, does the pain linger? ..... Y ❑ N ❑

b) cold foods or liquids? ..... Y ❑ N ❑ If yes, does the pain linger? ..... Y ❑ N ❑

c) when biting on certain foods or at certain times? ..... Y ❑ N ❑ If yes, does the pain linger? ..... Y ❑ N ❑

Do you clench or grind your jaws while sleeping or during the day? ..... Y ❑ N ❑

Do your jaws ever feel tired? ..... Y ❑ N ❑

Does your jaw joint (TMJ) ever click, pop or grind upon opening? ..... Y ❑ N ❑

If yes, does it bother you? ..... Y ❑ N ❑

Have you ever had any TMJ treatment? ..... Y ❑ N ❑ Approximate date of treatment _____

If yes, what treatment was performed? _____

Do you wear dentures? ..... Y ❑ N ❑ Do you gag easily? ..... Y ❑ N ❑

Please add anything you feel is important: _____

Cosmetic Concerns

Are you happy with your smile? ..... Y ❑ N ❑

Are you happy with the color of your teeth? ..... Y ❑ N ❑

Is there anything you would like to change about your smile, shape of teeth or tooth color? ..... Y ❑ N ❑

If yes, what change would you like to see? _____

Consent

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the information inquired above, have been answered to my satisfaction. I will not hold my dentist, or any member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form. **If my health history or medicine changes, I will inform the dentist or one of his/her staff members at my next appointment without fail.**

I understand the importance of a truthful health/dental history to assist the dentist in providing the best care possible. I have had the opportunity to discuss my health/dental history with my dentist.

I hereby grant authority to my dentist to administer any treatment with patient consent, or to administer anesthetics; and to perform such procedures as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

Authorization must be signed by the patient, or by the nearest relative in the case of a minor (under 18 years of age), or when the patient is physically or mentally incapacitated.

Signed _____ (patient or nearest relative) Relationship _____ Date _____

Print Name _____ Dentist's/Staff Signature _____