DENTAL HEALTH HISTORY:

Previous Dentist _____

When was your last dental visit? _____

For what purpose? _____

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 your teeth? _____

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 ❑

Have you ever been told you have gum disease? . . . . . Yes ❑ No ❑

If so, have you ever been treated for it? . . . . . Yes ❑ No ❑

When _____ By Whom _____

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 any of your teeth sensitive to air or during chewing? . . . . . Yes ❑ No ❑

What texture brush do you use? Soft ❑ Medium ❑ Hard ❑

Do you use an electric toothbrush? . . . . . Yes ❑ No ❑

If yes, which brand? _____

Do you chew on only one side of your mouth? . . . . . Yes ❑ No ❑

Does food catch between your teeth? . . . . . Yes ❑ No ❑

Do your feel your teeth are effecting your health in any way? . . . . . Yes ❑ No ❑

Have you ever had professional advice in dental home care? . . . . . Yes ❑ No ❑

Do you clench or grind your teeth while sleeping or during the day? . Yes ❑ No ❑

Have you ever been diagnosed with . . . . . Yes ❑ No ❑

Temporo-Mandibular Joint (TMJ) Dysfunction?

If yes, have you ever been treated for it? . . . . . Yes ❑ No ❑

When _____ By Whom _____

Do you wear full dentures? Yes ❑ No ❑ . . . . . Upper ❑ Lower ❑

Do you wear removable partial dentures? Yes ❑ No ❑ . . . . . Upper ❑ Lower ❑

Do you have retention problems with your full or partial dentures? . . . Yes ❑ No ❑

Do you gag easily? . . . . . Yes ❑ No ❑

Are you nervous about your dental treatment? . . . . . Yes ❑ No ❑

Please add anything you feel is important for the doctor to know:

_____

_____

_____

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. I understand that I am personally responsible for payment of any balance not paid by my insurer, including copays, deductibles and any amount in excess of my insurance company's usual and customary limitations.

_____

Patient Signature (Parent, if minor) Date

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 _____

NAME (Last) (First) (Middle) _____

HOME ADDRESS ZIP _____

BUSINESS ADDRESS _____

TELEPHONE (Home) (Business) _____

DATE OF BIRTH SEX HEIGHT WEIGHT _____

OCCUPATION EMPLOYER _____

MARITAL STATUS (circle) SINGLE MARRIED WIDOWED DIVORCED _____

SPOUSE'S NAME _____

DENTAL INSURANCE CARRIER (If applicable) _____

GROUP # _____

SOCIAL SECURITY NUMBER _____

REFERRED BY _____

Reason for your visit _____

Emergency information – Name, Address and Telephone Number of an individual we can contact: _____

_____

MEDICAL HEALTH:

General health (please check): Excellent ❑ Good ❑ Fair ❑ Poor ❑

Name and address of your physician _____

_____

Date of last complete physical _____

Are you presently under the care of a physician? . . . . . Yes ❑ No ❑

Is so, for what reason? _____

_____

Please list all medications you are currently taking . . . . . None ❑

_____

Check if you are allergic to penicillin ❑

Please list all other medications to which you have an allergy _____

_____

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

_____

_____

MEDICAL HEALTH HISTORY:

Have you had any radiation therapy to your head or neck? . . . . . Yes ❑ No ❑

Have you had any blood transfusions? . . . . . Yes ❑ No ❑

Do you smoke? Yes ❑ No ❑ How many per day? _____

Do you use smokeless tobacco? . . . . . Yes ❑ No ❑

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 ❑

If yes, has the change been an increase ❑ or decrease ❑?

Women: Are you pregnant? Yes ❑ No ❑ How long? _____

HIV Status: Negative ❑ Positive ❑ Unknown ❑

DO YOU HAVE A HISTORY OF THE FOLLOWING?

Chest Pains . . . . . Yes ❑ No ❑

Heart Disease . . . . . Yes ❑ No ❑

Rheumatic Fever . . . . . Yes ❑ No ❑
with Valvular Dysfunction

Congenital . . . . . Yes ❑ No ❑
Heart Defects

Stroke . . . . . Yes ❑ No ❑

Physiological, ... Yes ❑ No ❑
Functional or Innocent
Heart Murmur

Mitral Valve Prolapse . . . Yes ❑ No ❑
with Valvular Regurgitation

Prosthetic Heart Valve . . Yes ❑ No ❑

Postural Hypotension . . . Yes ❑ No ❑
(fainting spells)

Surgically Constructed . . . . . Yes ❑ No ❑
Systemic Pulmonary Shunt

Bacterial Endocarditis . . . . . Yes ❑ No ❑

Hypertrophic Cardiomyopathy . . . . . Yes ❑ No ❑

Ulcers . . . . . Yes ❑ No ❑

Tuberculosis or Lung Disease . . . . . Yes ❑ No ❑

Diabetes . . . . . Yes ❑ No ❑

Epilepsy . . . . . Yes ❑ No ❑

Anemia . . . . . Yes ❑ No ❑

Cancer . . . . . Yes ❑ No ❑

Psychiatric Problems . . . . . Yes ❑ No ❑

Alzheimer's Disease . . . . . Yes ❑ No ❑

Prosthetic Joints . . . . . Yes ❑ No ❑

Bruise Easily . . . . . Yes ❑ No ❑

Asthma or Hay Fever . . . . . Yes ❑ No ❑

Allergies or Hives . . . . . Yes ❑ No ❑

Sinus Trouble . . . . . Yes ❑ No ❑

Arthritis . . . . . Yes ❑ No ❑

Persistent Cough . . . . . Yes ❑ No ❑

Prolonged Bleeding Problems . . . . . Yes ❑ No ❑

Skin Disease . . . . . Yes ❑ No ❑

Latex Allergy . . . . . Yes ❑ No ❑

AIDS . . . . . Yes ❑ No ❑

Prolonged Sore Throat . . . . . Yes ❑ No ❑

Have you been informed by your physician of a need
to be premedicated with an antibiotic prior to all dental care? . . . . . Yes ❑ No ❑

Have you ever tested positive for Hepatitis B or C? . . . . . Yes ❑ No ❑

Have you been vaccinated for Hepatitis B? . . . . . Yes ❑ No ❑

Do you have a history of canker sores? . . . . . Yes ❑ No ❑