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PATIENT HEALTH RECORD

In order to help me render the proper dental services to you, would you please be kind enough to answer the following questions. Please note the space for remarks for any answers that require clarification or any other information you think I should have. Thank you for your cooperation.

Date: _____

Name: (Last) _____ (First) _____(Mid. Init.)_____

Home Address: (Street) _____

(City) _____ (Zip)_____

(Home Phone)_____(Cell Phone)_____

Date of Birth: _____Sex: _____ Height: _____ Weight: _____

Marital Status: Single _____ Married_____ Widowed _____ Divorced _____

If Married Spouse's Name: _____

Your Occupation: _____ Your Business Phone:_____

Your Social Security Number:_____

Employer:_____

Employer Address: _____

Insured D.O.B.: _____

Dental Insurance Company: _____

Name of Insured Employee: _____Social Security Number:_____

Group No.:_____ I.D. No.:_____

Referred by: _____

MEDICAL HEALTH

General Health: Excellent _____ Good_____ Fair_____ Poor _____

Name and Address of Physician: _____

_____

Date of Last Physical _____

Are You Taking Any Medication Now? Yes_____ No_____ List Meds:_____

Alcohol use ☐ None ☐ Social ☐ Regular

Are You Presently Being Treated For or Have You Been Treated For:

Heart Disease	Yes ___	No ___	Any communicable diseases	Yes ___	No ___
Rheumatic fever	Yes ___	No ___	Heart murmur	Yes ___	No ___
Abnormal Blood Pressure	Yes ___	No ___	Jaundice	Yes ___	No ___
Ulcers	Yes ___	No ___	Asthma or hay fever	Yes ___	No ___
Tuberculosis or lung disease	Yes ___	No ___	Sinus trouble	Yes ___	No ___
Diabetes	Yes ___	No ___	Cough	Yes ___	No ___
Epilepsy	Yes ___	No ___	Hepatitis	Yes ___	No ___
Anemia	Yes ___	No ___	Arthritis	Yes ___	No ___
Congenital heart lesions	Yes ___	No ___	Stroke	Yes ___	No ___
Glaucoma	Yes ___	No ___	AIDS/HIV	Yes ___	No ___

Do you smoke? Yes_____ No_____ How much?_____

Are You Allergic to: Penicillin _____ Codeine_____ Local Anesthetics_____

Other Medications _____

Are You Currently Under Cancer or Radiology Treatment? Yes ___ No ___

Are You Subject to Prolonged Bleeding? Yes ___ No ___

Are You Subject to Fainting Spells? Yes ___ No ___

Do You Have Excessive Urination and/or Thirst? Yes ___ No ___

(Women) Are You Pregnant? Yes ___ No ___

If yes, Expected Delivery Date:_____

Have You Ever Been Hospitalized? Yes ___ No ___

If so, When?_____ Why? _____

DENTAL HEALTH

Reason For Visit: _____

When Was Your Last Dental Visit? _____

Have You Ever Had A Serious Problem

Associated With Previous Dental Treatment . . . . . Yes ___ No ___

If so, Explain: _____

How Often Do You Brush Your Teeth? _____

What Texture Brush Do You Use? Soft _____ Medium _____ Hard _____ Nylon _____ Natural _____

How Often Do You Floss? _____

Do Your Gums Bleed While Brushing? . . . . . Yes ___ No ___

Do Your Gums Bleeds While Flossing? . . . . . Yes ___ No ___

Do You Avoid Brushing Any Part Of Your Mouth Because Of Pain? . . . . . Yes ___ No ___

If Yes, What Part? _____

Do You Feel Twinges Of Pain When Your Teeth Come in Contact With:

a) Hot Foods or Liquids, i.e., soup, coffee, tea, etc.? . . . . . Yes ___ No ___

b) Cold Foods or Liquids, i.e., ice cream, cold fruit, etc.? . . . . . Yes ___ No ___

c) Sweets, i.e., candy, fruit, sweet desserts, etc.? . . . . . Yes ___ No ___

d) Sours, i.e., lemons, limes, grapefruit, etc.? . . . . . Yes ___ No ___

Do You Feel Pain To Any Of Your Teeth When Brushing Or Flossing Them? . . . . . Yes ___ No ___

Do You Chew Only On One Side Of Your Mouth? . . . . . Yes ___ No ___

If yes, Explain: _____

_____

Do Your Gums Feel Tender Or Swollen? . . . . . Yes ___ No ___

Do You Clench Or Grind Your Jaws While Sleeping Or During The Day? . . . . . Yes ___ No ___

Do You Wear Dentures? . . . . . Yes ___ No ___

Do You Lose Fillings Or Break Fillings? . . . . . Yes ___ No ___

Do You Gag Easily? . . . . . Yes ___ No ___

Are You Familiar With The Term “Preventative Dentistry”? . . . . . Yes ___ No ___

Please Add Anything You Feel Is Important: _____

_____

_____

_____

_____

_____

_____

_____

Patient Signature

Emergency Contact Name & Number: _____ e-mail address: _____