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**Committed to Exceptional Quality & Service**

Patient Health Record
The following information is requested to assist the Doctor in
Administering the proper dental treatment.
Please answer the questions to the best of your ability.

Date_____

Name (Last)_____(First)_____(Middle)____

Home Address_____Zip Code_____

Business Address_____ZipCode_____

Home Phone_____Business_____Cell_____

Date Of Birth_____Sex_____Height_____Weight_____

Occupation_____Email(Home)_____

Marital Status(Check)_____Single_____Married____Widowed_____Divorced_____

Spouce's Name_____

Dental Insurance (Primary)_____(Member Name)_____

Dental Insurance (Secondary)_____(Member Name)_____

Social Secuirty (Primary Ins)_____(Secondary Ins.)_____

Referred By_____

Reason for your visit_____

Emergency Contact Information (Name)_____(Phone)_____

**MEDICAL HEALTH**
General Health (Please Check): Excellent____Good____Fair____Poor____

Name and Address of your Physican_____

Last Complete Physical_____

Are you presently under the care of a physician_____

If so, for what reason?_____

Are you taking any Medication? (Check) Yes_____ No_____

If Yes, please list all Medication_____

Meds_____

Are you Allergic to(check) Antibiotics____Codeine___Aspirin___Local Anesthetics___

Or any other Medication?_____

Have you ever been hospitalized? If so give Name of Hospital_____

Reason_____

Dates_____

Have you had any radiological diagnostic x-rays in the last five years? Yes____No____

Have you had any blood transfusions? ……Yes____No____

Are you currently trying to modify your weight?.....Yes____No____

Do you take any medication to help in weight reduction?.....Yes____No____

Do you smoke cigarettes?.....Yes____No____

Do you consume alcohol on a daily basis?.....Yes____No____

Is your blood pressure (Check) 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___ Postural Hypotension(Fainting Spells)...Yes____No____

Heart Diease…….Yes___No___ Hypertension……..Yes____No___

Rheumatic Fever……Yes__No___ Kidney Problems……Yes____No____

Congenital Heart Defects..Yes__No___ Stroke……..Yes____No____

Heart Murmur……..Yes___No___ Hepatitis……..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____

Asthmas 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……..Yes____No____
(Gonorrhea, Syphilis, Genital Herpes)

Genetic Problems…….……..……Yes____No____

Skin Disease…….……..…Yes____No____

AIDS……...…Yes____No____

Have you ever been tested for AIDS?.....Yes____No____

Are you HIV Positive?.....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____

Do you have a history of Cold Sores, Fever Blisters, or Canker Sores?.....
……..Yes____No____

Are you being treated with Immunosuppressive Drugs?...Yes____No____

**DENTAL HSITORY**

When was your last dental visit? _____

Have you ever had any serious problems associated with previous dental treatment?

Yes____No____ If yes, explain:_____

Do you routinely use a mouth rinse?.....Yes____No____ How often?_____

Do you experience dry mouth (Xerostomia)?.....Yes____No____

Do your gums bleed whole 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 any of your teeth sensitive to air or during chewing?.....Yes____No____

What Texture Brush do you use?.....Soft____Medium____Hard____

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 professional advice in dental home care?.....Yes____No____

Do you clench or grind your teeth while sleeping or during the day?_Yes__No___

Do your facial muscles ever feel tired?.....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 patients dental of oral facial needs including x-rays, study models, photographs, medications and the use of local anesthetic agents.

PATIENT SIGNATURE_____DATE_____

DENTIST SIGNATURE_____DATE_____