Patient Health Record

In order to help us 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 we should have. Thank you for your cooperation.

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ANGINAUNUSUAL BLEEDINGTUBERCULOSIS TYPECONGESTIVE HEART FAILUREFAINTING SPELLSPARESTHESIA (NUMBNESS)RACING HEART EPILEPSY/SEIZURESPARALYSIS OF ARM, LEG, ETCIRREGULAR HEART BEAT STROKE /E YOU EVER BEEN TREATED FOR CANCER?	VE YOU BEEN TREATED FOR: MITRAL VALVE PROLAPSEHEART MURMURRHEUMATIC FEVERCONGENITAL HEART LESIONSHEART SURGERYHEART VALVE PROSTHESIS	JOINT REPLACEMENT HEPATITIS L A TYPE INFECTIOUS B TYPE SERUM VENEREAL DISEASE AIDS ARC	DIABETES KIDNEY DISEASE JAUNDICE GLAUCOMA ASTHMA HAY FEVER	WHEN CLEFT PALATE/LIP SPEECH DEFECTS THYROID DISEASE ARTHRITIS PSYCHIATRIC CARE HEADACHE
CONGESTIVE HEART FAILUREFAINTING SPELLSPARESTHESIA (NUMBNESS)RACING HEART EPILEPSY/SEIZURESPARALYSIS OF ARM, LEG, ETCIRREGULAR HEART BEAT STROKE /E YOU EVER BEEN TREATED FOR CANCER?	/E YOU BEEN TREATED FOR: MITRAL VALVE PROLAPSEHEART MURMURRHEUMATIC FEVERCONGENITAL HEART LESIONSHEART SURGERYHEART VALVE PROSTHESISCARDIAC PACEMAKER	JOINT REPLACEMENT HEPATITIS —— A TYPE INFECTIOUS —— B TYPE SERUM VENEREAL DISEASE — AIDS —— ARC — HIGH BLOOD PRESSURE	DIABETES KIDNEY DISEASE JAUNDICE GLAUCOMA ASTHMA HAY FEVER SINUS TROUBLE	WHEN CLEFT PALATE/LIP SPEECH DEFECTS THYROID DISEASE ARTHRITIS PSYCHIATRIC CARE HEADACHE ULCERS
	/E YOU BEEN TREATED FOR: MITRAL VALVE PROLAPSE HEART MURMUR RHEUMATIC FEVER CONGENITAL HEART LESIONS HEART SURGERY HEART VALVE PROSTHESIS CARDIAC PACEMAKER CHEST PAINS	JOINT REPLACEMENT HEPATITIS A TYPE INFECTIOUS B TYPE SERUM VENEREAL DISEASE AIDS ARC HIGH BLOOD PRESSURE LOW BLOOD PRESSURE	DIABETES KIDNEY DISEASE JAUNDICE GLAUCOMA ASTHMA HAY FEVER SINUS TROUBLE PERSISTENT COUGH	WHEN
STROKE /E YOU EVER BEEN TREATED FOR CANCER?	/E YOU BEEN TREATED FOR: MITRAL VALVE PROLAPSEHEART MURMURRHEUMATIC FEVERCONGENITAL HEART LESIONSHEART SURGERYHEART VALVE PROSTHESISCARDIAC PACEMAKERCHEST PAINSANGINA	JOINT REPLACEMENT HEPATITIS A TYPE INFECTIOUS B TYPE SERUM VENEREAL DISEASE AIDS ARC HIGH BLOOD PRESSURE LOW BLOOD PRESSURE UNUSUAL BLEEDING	DIABETES KIDNEY DISEASE JAUNDICE GLAUCOMA ASTHMA HAY FEVER SINUS TROUBLE PERSISTENT COUGH TUBERCULOSIS	WHEN
VE YOU EVER HAD RADIATION THERAPY?	VE YOU BEEN TREATED FOR: MITRAL VALVE PROLAPSE HEART MURMUR RHEUMATIC FEVER CONGENITAL HEART LESIONS HEART SURGERY HEART VALVE PROSTHESIS CARDIAC PACEMAKER CHEST PAINS ANGINA CONGESTIVE HEART FAILURE	JOINT REPLACEMENT HEPATITIS A TYPE INFECTIOUS B TYPE SERUM VENEREAL DISEASE AIDS ARC HIGH BLOOD PRESSURE LOW BLOOD PRESSURE UNUSUAL BLEEDING FAINTING SPELLS	DIABETES KIDNEY DISEASE JAUNDICE GLAUCOMA ASTHMA HAY FEVER SINUS TROUBLE PERSISTENT COUGH TUBERCULOSIS PARESTHESIA (NUMBNESS)	WHEN
YOU SMOKE? YES NO HOW MUCH?	VE YOU BEEN TREATED FOR: MITRAL VALVE PROLAPSE HEART MURMUR RHEUMATIC FEVER CONGENITAL HEART LESIONS HEART SURGERY HEART VALVE PROSTHESIS CARDIAC PACEMAKER CHEST PAINS ANGINA CONGESTIVE HEART FAILURE RACING HEART	JOINT REPLACEMENT HEPATITIS A TYPE INFECTIOUS B TYPE SERUM VENEREAL DISEASE AIDS ARC HIGH BLOOD PRESSURE LOW BLOOD PRESSURE UNUSUAL BLEEDING FAINTING SPELLS EPILEPSY/SEIZURES	DIABETES KIDNEY DISEASE JAUNDICE GLAUCOMA ASTHMA HAY FEVER SINUS TROUBLE PERSISTENT COUGH TUBERCULOSIS PARESTHESIA (NUMBNESS)	WHEN WHEN
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MEN: HAVE YOU REACHED MENOPAUSE? YES NO IF SO, ARE YOU TAKING ANY SUPPORTIVE MEDICATION?	VE YOU BEEN TREATED FOR: MITRAL VALVE PROLAPSE HEART MURMUR RHEUMATIC FEVER CONGENITAL HEART LESIONS HEART SURGERY HEART VALVE PROSTHESIS CARDIAC PACEMAKER CHEST PAINS ANGINA CONGESTIVE HEART FAILURE RACING HEART IRREGULAR HEART BEAT	JOINT REPLACEMENT HEPATITIS A TYPE INFECTIOUS B TYPE SERUM VENEREAL DISEASE AIDS ARC HIGH BLOOD PRESSURE LOW BLOOD PRESSURE UNUSUAL BLEEDING FAINTING SPELLS EPILEPSY/SEIZURES STROKE	DIABETES KIDNEY DISEASE JAUNDICE GLAUCOMA ASTHMA HAY FEVER SINUS TROUBLE PERSISTENT COUGH TUBERCULOSIS PARESTHESIA (NUMBNESS) PARALYSIS OF ARM, LEG, ETC.	WHEN CLEFT PALATE/LIP SPEECH DEFECTS THYROID DISEASE ARTHRITIS PSYCHIATRIC CARE HEADACHE ULCERS NEUROMUSCULAR DISEASE TYPE WHEN
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NTAL HISTORY						
REASON FOR VISIT						
WHEN WAS YOUR LAST DENTAL VISIT						
HAVE YOU EVER HAD ANY SERIOUS PROBLEM	ASSOCIATED WITH	PREVIOUS DENTAL TREATM	ENT?		YES	N
IF SO, EXPLAIN:						
HOW OFTEN DO YOU BRUSH YOUR TEETH?						
WHAT TEXTURE BRUSH DO YOU USE? DO YOU FLOSS?	SOFT	MEDIUM HOW OFTEN	HARD	NAFON	NATURAL	
DO YOUR GUMS BLEED WHILE BRUSHING?	. ,				YES	N
DO YOUR GUMS BLEED WHEN FLOSSING?					YES	N
DO YOU AVOID BRUSHING OR FLOSSING ANY PA		H BECAUSE OF PAIN?			YES	N
HAVE YOU EVER HAD PERIODONTAL (GUM) TRE					YES	N
IF YES, WHEN AND BY WHOM?					VEC	N
HAVE YOU EVER HAD ORTHODONTIC TREATMEN					YES	N
IF YES, WHEN AND BY WHOM?						
DO YOU FEEL TWINGES OF PAIN WHEN YOUR A) HOT FOODS OR LIQUIDS, i.e. SOUP, COFF					YES	N
B) COLD FOODS OR LIQUIDS, i.e. ICE CREAM						
C) SWEETS I.e. CANDY, FRUIT, SWEET DESSE						
D) SOURS i.e. LEMONS, LIMES, GRAPEFRUIT						
DO YOU CHEW ON ONLY ONE SIDE OF YOUR MO						
DO YOUR GUMS FEEL TENDER OR SWOLLEN?					YES	N
DO YOU CLENCH OR GRIND YOUR JAWS WHILE						N
DO YOUR JAWS EVER FEEL TIRED?						N
DO YOU WEAR DENTURES?						N
DO YOU USUALLY HAVE MANY CAVITIES?					YES	
DO YOU LOSE FILLINGS OR BREAK FILLINGS?					YES	•
DO YOU GAG EASILY?					YES	
ERSONALIZED ESTHETIC EVALUA	TION					
IF YOUR SMILE WERE IMPROVED, WOULD YOU F	EEL MORE CONFIDER	NT?			YES	
DO YOU LIKE THE COLOR OF YOUR TEETH?					YES	
DO YOU HAVE SPACES BETWEEN YOUR TEETH?	?				YES	
DO THESE SPACES BOTHER YOU?					YES	. 1
DO YOU HAVE CHIPS OR UNEVEN EDGES ON YOU	UR TEETH?				YES	1
DOES THE SHAPE OF YOUR TEETH BOTHER YO	U?				YES	. 1
DO YOU FEEL THAT YOUR TEETH ARE TOO CRO	WDED?				YES	. 1
ARE YOUR TEETH NOTCHED AT THE GUMLINE?					YES	
DO YOUR GUMS LOOK AND FEEL HEALTHY?					YES	
ARE YOUR TEETH TOO SHORT?					YES	
ARE YOUR TEETH TOO LONG?					YES	
EASE ADD ANYTHING YOU FEEL IS IMPORTANT:						

FINANCIAL TERMS & CONDITIONS

SIGNED:

As a condition of your treatment by this office, financial arrangements must be made in advance. Our practice depends upon reimbursement from the patients for the cost incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without prior financial arrangements, must be paid at the time the services are performed. All elective, cosmetic dentistry is payable by either the total amount in advance or half of the fee in advance and the balance upon delivery of the dental work.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will provide the dentist's statement of services to assist patient reimbursement from insurance companies. This office will not render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) will be charged directly on the unpaid balance on all accounts exceeding 30 days, unless previous written financial arrangements are satisfied.

I understand that the fee estimate quoted for this dental case can only be extended for a period of six months from the date of the patient's examination.

All xrays, photos, and other diagnostic aids may be used as teaching aids. We will release copies of all of these records to the patient or other professionals by submitting a written request.

Date Charted: В L Labio-buccal Lingual RIGHT Lingual Labio-buccal В