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.

DATE:_____

NAME: _____ PREFERRED NAME:_____
(LAST) (FIRST) (MIDDLE)

HOME ADDRESS: _____ HOME PHONE:_____
(CITY) (ZIP CODE)

EMAIL ADDRESS: _____ CELL PHONE: _____

BILLING ADDRESS: _____
(IF DIFFERENT THAN HOME ADDRESS) (CITY) (ZIP CODE)

OCCUPATION: _____ COMPANY NAME: _____

BUSINESS ADDRESS: _____ BUSINESS PHONE:_____
(CITY) (ZIP CODE)

DATE OF BIRTH:_____ SEX:_____ HT:_____ WT:_____

MARITAL STATUS:_____ SOCIAL SECURITY NUMBER:_____(for dental insurance only)

SPOUSE'S NAME:_____
(PARENT'S NAME IF MINOR)

_____ _____
(REFERRED TO OUR OFFICE BY:)

MEDICAL HISTORY

NAME AND ADDRESS OF PHYSICIAN: _____

_____

LAST COMPLETE PHYSICAL: _____

ARE YOU ALLERGIC TO: PENICILLIN ☐ CODEINE ☐ LOCAL INJECTED ANESTHETICS ☐ OTHER MEDICATIONS_____

ARE YOU TAKING ANY MEDICATIONS? ☐ YES ☐ NO NAME OF MEDICATION _____ FOR WHAT PURPOSE _____

_____ _____

HAVE YOU EVER BEEN HOSPITALIZED? ☐ YES ☐ NO FOR WHAT PURPOSE _____ WHEN _____

HAVE 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.

_____ CLEFT PALATE/LIP
_____ SPEECH DEFECTS
_____ THYROID DISEASE
_____ ARTHRITIS
_____ PSYCHIATRIC CARE
_____ HEADACHE
_____ ULCERS
_____ NEUROMUSCULAR DISEASE
TYPE_____

HAVE YOU EVER BEEN TREATED FOR CANCER? ☐ YES ☐ NO LOCATION/TYPE _____ WHEN_____

HAVE YOU EVER HAD RADIATION THERAPY? ☐ YES ☐ NO CHEMOTHERAPY ☐ YES ☐ NO WHEN _____

DO YOU SMOKE? ☐ YES ☐ NO HOW MUCH?_____

WOMEN: HAVE YOU REACHED MENOPAUSE? ☐ YES ☐ NO IF SO, ARE YOU TAKING ANY SUPPORTIVE MEDICATION? _____

ARE YOU PREGNANT? ☐ YES ☐ NO DUE DATE_____

EVERYONE ANSWER PLEASE: DO YOU HAVE ANY OTHER DISEASE, CONDITION, OR PROBLEM NOT LISTED ..... YES NO

IF *YES*, PLEASE EXPLAIN: _____

_____

DENTAL HISTORY

REASON FOR VISIT _____

WHEN WAS YOUR LAST DENTAL VISIT _____

HAVE YOU EVER HAD ANY 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

DO YOU FLOSS? _____ HOW OFTEN? _____

DO YOUR GUMS BLEED WHILE BRUSHING? ..... YES NO

DO YOUR GUMS BLEED WHEN FLOSSING? ..... YES NO

DO YOU AVOID BRUSHING OR FLOSSING ANY PART OF YOUR MOUTH BECAUSE OF PAIN? ..... YES NO

IF YES, WHAT PART? _____

HAVE YOU EVER HAD PERIODONTAL (GUM) TREATMENT? ..... YES NO

IF YES, WHEN AND BY WHOM? _____

HAVE YOU EVER HAD ORTHODONTIC TREATMENT? ..... YES NO

IF YES, WHEN AND BY WHOM? _____

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 CHEW ON ONLY ONE SIDE OF YOUR MOUTH? ..... YES NO

IF SO, 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 YOUR JAWS EVER FEEL TIRED? ..... YES NO

DO YOU WEAR DENTURES? ..... YES NO

DO YOU USUALLY HAVE MANY CAVITIES? ..... YES NO

DO YOU LOSE FILLINGS OR BREAK FILLINGS? ..... YES NO

DO YOU GAG EASILY? ..... YES NO

PERSONALIZED ESTHETIC EVALUATION

IF YOUR SMILE WERE IMPROVED, WOULD YOU FEEL MORE CONFIDENT? ..... YES NO

DO YOU LIKE THE COLOR OF YOUR TEETH? ..... YES NO

DO YOU HAVE SPACES BETWEEN YOUR TEETH? ..... YES NO

DO THESE SPACES BOTHER YOU? ..... YES NO

DO YOU HAVE CHIPS OR UNEVEN EDGES ON YOUR TEETH? ..... YES NO

DOES THE SHAPE OF YOUR TEETH BOTHER YOU? ..... YES NO

DO YOU FEEL THAT YOUR TEETH ARE TOO CROWDED? ..... YES NO

ARE YOUR TEETH NOTCHED AT THE GUMLINE? ..... YES NO

DO YOUR GUMS LOOK AND FEEL HEALTHY? ..... YES NO

ARE YOUR TEETH TOO SHORT? ..... YES NO

ARE YOUR TEETH TOO LONG? ..... YES NO

PLEASE ADD ANYTHING YOU FEEL IS IMPORTANT: _____

_____

_____

_____

_____

FINANCIAL TERMS & CONDITIONS

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.

SIGNED: _____ DATE: _____

Date Charted: