PATIENT HISTORY

We practice the concept of "Optimum Dental Health." This is the most favorable degree of oral health that you, as a patient, can attain with our help. As a patient, your feelings and goals can determine what level of care we can achieve by working together. We believe that your dental treatment should be directed by your desires and decisions.

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Home Phone # _____ Work Phone # _____ Mobile _____

Patient Email: _____

Soc. Sec. # _____ Birthdate _____ Age _____

❑ Married ❑ Single ❑ Divorced ❑ Widowed Spouse's Name _____

Referred to our office by _____

INSURANCE

Primary Carrier

Carrier Name _____

Subscriber _____

Birthdate _____

Employed by _____

Union or Local # _____

Aid or Group # _____

Member # _____

Date Employed _____

Social Security # _____

Secondary Carrier

Carrier Name _____

Subscriber _____

Birthdate _____

Employed by _____

Union or Local # _____

Aid or Group # _____

Member # _____

Date Employed _____

Social Security # _____

DENTAL

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Circle Yes or No, whichever applies, in response to the following questions. Your answers are for our records only and will be considered confidential.

1. Are you having any discomfort at this time? ..... Yes No
2. Have you ever had any serious trouble associated with previous dental treatment? ..... Yes No
   If so, explain: _____
3. Does dental treatment make you nervous? ❑ No ❑ Slightly ❑ Moderately ❑ Extremely
4. Date of last dental visit: _____
5. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? ..... Yes No
   If so, when? _____
6. How often do you brush? _____
   Brush is: ❑ Soft ❑ Medium ❑ Hard
7. Do you have or have you ever had any of the following? _____

MOUTH

Bleeding, sore gums	Yes	No
Unpleasant taste/bad breath	Yes	No
Burning tongue/lips	Yes	No
Frequent blisters, lips/mouth	Yes	No
Swelling/lumps in mouth	Yes	No
Orthodontic treatments (braces)	Yes	No
Biting cheeks/lips	Yes	No
Clicking/popping jaw	Yes	No
Difficulty opening or closing jaw	Yes	No

TEETH

Loose teeth	Yes	No
Sensitive to hot	Yes	No
Sensitive to cold	Yes	No
Sensitive to sweets	Yes	No
Sensitive to biting	Yes	No
Food impaction	Yes	No
Clenching/grinding	Yes	No
If so, when? _____		
Shifting in bite	Yes	No
Change in bite	Yes	No

8. Do you use the following?

Brush	Yes	No
Dental floss	Yes	No
Fluoride rinse	Yes	No

Other _____

continued on reverse

MEDICAL

1. Have you been examined by your doctor within the past year? ..... Yes No

2. Do you need to be premedicated with an antibiotic prior to dental work? ..... Yes No

3. Have you consulted specialists within the past year? ..... Yes No

4. Are you taking any medication? ..... Yes No
   What? _____ Why? _____
   What? _____ Why? _____
   What? _____ Why? _____

5. Do you have any medical problems? ..... Yes No
   If Yes, explain: _____

6. Have you ever had a major operation? ..... Yes No

7. Have you ever had radiation therapy, chemotherapy or cortisone therapy? ..... Yes No

8. Do you bruise or swell easily? ..... Yes No

9. Do you get infections easily? ..... Yes No

10. Do you smoke? ..... Yes No

11. Have you ever had any of the following diseases or symptoms:

A. Rheumatic fever or rheumatic heart disease?	Yes	No	I. Artificial prothesis?	Yes	No
B. Heart disease or mitral valve prolapse?	Yes	No	J. Diabetes?	Yes	No
C. Chest pains or shortness of breath on mild exertion?	Yes	No	K. Ulcer?	Yes	No
D. Rheumatism or arthritis?	Yes	No	L. Asthma?	Yes	No
E. Prolonged bleeding?	Yes	No	M. Stroke?	Yes	No
F. High blood pressure?	Yes	No	N. Seizures?	Yes	No
G. Low blood pressure?	Yes	No	O. Cancer?	Yes	No
H. AIDS (HIV virus)?	Yes	No	P. Hepatitis?	Yes	No

12. Have you ever experienced any reaction to the following drugs:

A. Aspirin?	Yes	No	C. Penicillin?	Yes	No
B. Codeine?	Yes	No	D. Local anesthetics?	Yes	No

13. Any other allergy? _____

14. Is there a chance that you could be pregnant? ..... Yes No

At subsequent appointments, please inform us of any changes in your health.

Emergency Contact Name _____ Phone _____

Patient's or Authorized Person's Signature _____ Date _____