

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) (Middle)

*Home Address _____
(Street) (City) (State) (Zip)

*Patient Social Security # _____ Date of Birth _____ *FL Lic. # _____

*Home # _____ *Cell# _____ *Work # _____

Email Address _____ (H) _____ (C) _____

Nearest Relative _____ Marital Status (Check) Single Married Widowed Divorced

Employer _____ Employer's Address _____
(Street) (City) (State) (Zip)

Spouse's Name _____ Who will be financially responsible for this account? _____

Insured's Employer _____

*Insured Social Security # _____ *Insurance Company _____

Referred by _____ Group # _____

PHYSICAL HEALTH

General health (please check): EXCELLENT GOOD POOR

Name and address of physician _____ Date Last Complete Physical _____

Are you taking any medication now ? Yes No If yes, list medication and reason below:

Medication or Drug _____	Reason _____
Medication or Drug _____	Reason _____
Medication or Drug _____	Reason _____

HAVE YOUR EVER BEEN TREATED FOR:

- Heart Disease Yes No
- Mitral Value Prolapse Yes No
- By-Pass Surgery Yes No
- Joint Replacement Yes No
- Rheumatic Fever Yes No
- Ulcers Yes No
- Turberculosis or lung disease Yes No
- Diabetes Yes No
- Epilepsy Yes No
- Congenital heart lesions Yes No
- Do you have a pacemaker Yes No

- Do you take Aspirin daily ? Yes No
- Heart murmur Yes No
- Jaundice Yes No
- Anemia Yes No
- Asthma or hay fever Yes No
- Sinus trouble Yes No
- Cough Yes No
- Hepatitis Yes No
- Arthritis Yes No
- Stroke Yes No
- Glaucoma Yes No
- AIDS Yes No
- HIV Positive Yes No

Have you ever been treated (other than diagnostic) with x-ray ? Yes No

Are you aleergic to Penicillin Codeine Local injected anesthetics Other medications _____

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 How long ? _____

Patient signature

(over)

DENTAL HEALTH

Reason for visit: _____

When was your last dental visit? _____

Have you ever had any serious problems associated with previous dental treatment? Yes No

Is so, explain: _____

Would you be interested in implants to replace your missing teeth or to better serve your existing denture? Yes No

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 bleed when 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 on only one side of your mouth? Yes No

If yes, explain: _____

Do you have any neck or shoulder pain? _____

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 or have pain or clicking sounds? Yes No

Do you wear dentures? / Do they seem to fit well? 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

Do you like the looks of your teeth? Yes No

Are your teeth badly stained or discolored? Yes No

Are you familiar with term "preventive dentistry"? Yes No

Have you considered dental implants? Yes No

Please add anything you feel is important: _____

(Patient signature)