DENTAL HEALTH

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When was your last dental visit? _____
Have you ever had any serious problems associated with previous dental treatment?
Yes ❒ No ❒ If yes, explain: _____
How often do you brush your teeth? _____
How often do you floss? _____
Do you routinely use a mouth rinse? Yes ❒ No ❒ How often? _____
Do you experience dry mouth (Xerostomia)? ..... Yes ❒ No ❒
Do your gums feel tender or swollen? ..... Yes ❒ No ❒
Do your gums bleed while 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 ❒
Do you chew on only one side of your mouth? ..... Yes ❒ No ❒
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 wear full dentures? Upper ❒ Lower ❒ ..... Yes ❒ No ❒
Do you wear partial dentures? Upper ❒ Lower ❒ ..... Yes ❒ No ❒
Do you have retention problems with your full or partial dentures? ..... Yes ❒ No ❒
Do you gag easily? ..... Yes ❒ No ❒
I Are you apprehensive (nervous) about your dental treatment? ..... Yes ❒ No ❒
If yes - have you had: Nitrous Oxide ❒ Medication prior to treatment ❒
Is there anything about your smile or your teeth you do not like?

_____
_____
_____

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 or oral-facial needs including x-rays, study models, photographs, medications, and the use of local anesthetic agents.

_____
PATIENT SIGNATURE (PARENT OF CHILD) DATE

_____
DENTIST SIGNATURE DATE

Patient Health Record

The following information is requested to assist the Doctor in administering the proper dental service. Please answer the questions to the best of your ability, and use the additional space for answers requiring clarification or any additional information.
Thank you for your cooperation. Please use black ink.

DATE _____ PATIENT NUMBER _____

NAME (Last) _____ (First) _____ (Middle) _____

HOME ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

PHONE (Home) _____ (Cell) _____ (Work) _____

DATE OF BIRTH _____ SEX _____ HEIGHT _____ WEIGHT _____

OCCUPATION _____

MARITAL STATUS (Circle one) SINGLE MARRIED WIDOWED DIVORCED

SPOUSE'S NAME _____

TYPE OF DENTAL INSURANCE (If applicable) _____

SOCIAL SECURITY NUMBER _____

HOW DID YOU HEAR ABOUT US? ❒ OUR CORNER SIGN
❒ OUR BUSINESS CARD ❒ VERIZON PHONE BOOK ❒ OUR WEBSITE
❒ OUR OFFICE STAFF ❒ A FRIEND _____ ❒ OTHER _____

Reason for your visit _____

Emergency information - name, address and telephone of an individual we can call:

_____

_____

MEDICAL HEALTH

General health (please check): Excellent ❒ Good ❒ Fair ❒ Poor ❒
Name and address of your physician _____

_____

Last complete physical? _____

Are you presently under the care of a physician? ..... Yes ❒ No ❒

If so, for what reason? _____

_____

Are you taking any medication now? Yes ❒ No ❒ _____

_____

If Yes, please list all Medications. _____

_____

Are you allergic to: Antibiotics ❒ Codeine ❒ Aspirin ❒ Local ❒ Anesthetics ❒

Or any other Medications? _____

Have you ever been hospitalized? If so give name of hospital, reason and 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 medications to help in weight reduction? ..... Yes ❒ No ❒
Do you smoke cigarettes? Yes ❒ No ❒ How many per day? _____
Do you consume alcohol on a daily basis? ..... Yes ❒ No ❒
Is your blood pressure 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 ❒
Heart Disease ..... Yes ❒ No ❒
Rheumatic Fever ..... Yes ❒ No ❒
Congenital Heart Defects . Yes ❒ No ❒
Heart Murmur ..... Yes ❒ No ❒
Postural Hypotension ..... Yes ❒ No ❒
{fainting spells}
Hypertension ..... Yes ❒ No ❒
Kidney Problems ..... Yes ❒ No ❒
Stroke ..... 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 ❒
Asthma 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 ❒
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 ❒

Have you ever been tested for Hepatitis? ..... 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 ❒
Have you ever used drugs for recreational purposes? ..... Yes ❒ No ❒