~DENTAL HEALTH~

When was your last dental visit? _____

Have you ever had serious problems associated with any dental treatment? YES ☐ NO ☐

If yes, explain: _____

How often do you brush your teeth? _____

How often do you floss? _____

Do you routinely use mouthwash? 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 contact hot, cold, sweet or sour? YES ☐ NO ☐

Are your teeth sensitive to air or during chewing? YES ☐ NO ☐

What texture brush do you use? _____

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 anyway? 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? YES ☐ NO ☐

Do you wear partial dentures? YES ☐ NO ☐

Do you have any retention problems with your full or partial dentures? YES ☐ NO ☐

Do you gag easily? YES ☐ NO ☐

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 diagnostic diagnosis of the patient's 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**

Malvin Family Dentistry

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: _____

ADDRESS: _____

CITY: _____ **ST:** _____ **ZIP:** _____ **DATE OF BIRTH:** _____

PHONES
HOME: _____ **CELL:** _____ **WORK:** _____

EMAIL: _____

OCCUPATION: _____ **HEIGHT:** _____ **WEIGHT:** _____

SEX: ❑ **M** ❑ **F** **MARITAL STATUS:** ❑ **MARRIED** ❑ **SINGLE** ❑ **WIDOWED** ❑ **DIVORCED**

SOCIAL SECURITY #: _____ **SPOUSE'S NAME:** _____

TYPE OF DENTAL INSURANCE *(if applicable)*: _____

HOW DID YOU HEAR ABOUT US? ❑ **OUR CORNER SIGN** ❑ **OUR BUSINESS CARD** ❑ **OUR OFFICE STAFF** ❑ **OUR WEBSITE** ❑ **A FRIEND** ❑ **INTERNET SEARCH** ❑ **OTHER** _____

REASON FOR YOUR VISIT: _____

PERSON TO CONTACT IN CASE OF EMERGENCY

NAME: _____ **PHONE:** _____

ADDRESS: _____ **CITY:** _____

~MEDICAL HEALTH~

GENERAL HEALTH *(please check)*: **EXCELLENT** ❑ **GOOD** ❑ **FAIR** ❑ **POOR** ❑

YOUR PHYSICIAN'S INFORMATION. NAME: _____

ADDRESS: _____

PHONE: _____ **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? .....YES ❑ NO ❑

If so, give name of hospital, reason and dates _____

_____

Is antibiotic pre-medication needed prior to dental procedures?.....YES ❑ NO ❑

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 ❑

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 does drugs?.....YES ❑ NO ❑

Have you ever use drugs for recreational purposes?.....YES ❑ NO ❑

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❑

Surgery Date: _____

Bruise Easily.....YES❑ NO❑

Jaundice .....YES❑ NO❑

Asthma or Hayfever.....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❑

Prolong 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❑