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 Physicial

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 alelergic 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 ? ____________________

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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 your 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: ______________________________

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(Patient signature)