PATIENT HEALTH RECORD

Date ______________________

Name ______________________________________ Preferred Name ______________________________

Address ___________________________________City ____________________ State ____ Zip________

Home Phone _________________ Work Phone ___________________ Cell Phone __________________

Email address ____ SS# ______________________

Occupation_________________________ Business Address _____________________________________

Date of Birth ________________ Sex ______ Height ________ Weight _________ Single ______ Married _______

Spouse's Name _________________ Occupation _______________________ Phone _________________

Whom may we thank for referring you to us? ____

MEDICAL HEALTH

Please rate your medical health from 1 (poor) - 10 (best)____

Have you ever had a major surgery? ☐ yes ☐ no What kind of surgery? _______________________________

Complications ____

Are you allergic to any medications or substances? Please check below:

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Sulfa ☐ Latex Rubber ☐ Other _________________________________

Smoker ☐ Yes ☐ No How much? ____

WOMEN: ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives

Do you have any artificial joints? ____ Yes ____ No
Do you have an artificial heart valve? ____ Yes ____ No
Do you require an antibiotic pre-medication before your dental visit? ____ Yes ____ No
Do you take or have you taken bisphosphonates? i.e., Boniva, Fosamax, Reclast, Actonel ____ Yes ____ No
Have you been out of the country within the last 2 to 3 months? ____Yes ____No

Are you taking any medications, pills or drugs? ☐ Yes ☐ No Please list ________________________________

Have you ever had any of the following? Please circle Yes or No

	Yes No		Yes No		Yes No		Yes No
Heart Trouble/Disease	Y N	Bruise Easily	Y N	Emphysema	Y N	Kidney Problems	Y N
Heart Murmur	Y N	Anemia	Y N	Tuberculosis	Y N	Renal Dialysis	Y N
Irregular Heart Beat	Y N	Excessive Bleeding	Y N	Cancer	Y N	Thyroid Disease	Y N
Angina/Chest Pain	Y N	Sickle Cell Disease	Y N	Radiation Treatment	Y N	Parathyroid Disease	Y N
Heart Attack/Failure	Y N	Hemophilia (bleeding)	Y N	Chemotherapy	Y N	Arthritis/Gout	Y N
Congenital Heart Prob.	Y N	Leukemia	Y N	Stomach/intes. Dis.	Y N	Rheumatism	Y N
Mitral Valve Prolapse	Y N	Blood Transfusion	Y N	Ulcers	Y N	Pain in Jaw Joints	Y N
Rheumatic Fever	Y N	Lung Disease	Y N	Recent weight loss	Y N	Cortisone Medicine	Y N
Tumors or growths	Y N	Breathing Problems	Y N	Frequent Diarrhea	Y N	Psychiatric Care	Y N
Heart Pacemaker	Y N	Shortness of Breath	Y N	Diabetes	Y N	Venereal Disease	Y N
Heart Surgery	Y N	Frequent Cough	Y N	Excessive Thirst	Y N	AIDS	Y N
High Blood Pressure	Y N	Hay Fever	Y N	Hypoglycemia	Y N	HIV Positive	Y N
Low Blood Pressure	Y N	Sinus Trouble	Y N	Liver Disease	Y N	Drug Addiction	Y N
Blood Disease	Y N	Asthma	Y N	Hepatitis A (Infectious)	Y N	Alzheimer's Disease	Y N
Steroid Therapy	Y N	Stroke	Y N	Hepatitis B (Serum)	Y N	Allergies (Medicines)	Y N
Cold Sores	Y N	Convulsions	Y N	Hepatitis C	Y N	Allergies (pollen/dust)	Y N
Fever Blisters	Y N	Epilepsy or Seizures	Y N	Glaucoma	Y N	Hives or Rash	Y N
						Fainting or Dizziness	Y N

- Are you now under the care of a physician? ☐ Yes ☐ No

  If yes, please explain: ____

- Name of Physician: ____ Phone: _________________________

- Do you have any health problems that need further clarification? ☐ Yes ☐ No

  If yes, please explain: ____

DENTAL HEALTH

1. Please rate your dental health from 1 (poor) – 10 (best) ________
2. When was your last dental visit? ________________________________
3. Do you have a specific dental problem? ☐ *Yes* ☐ *No* *Describe* ____
4. Does any of the following cause tooth discomfort? ☐ *Hot* ☐ *Cold* ☐ *Sweets* ☐ *Chewing*

21. Do you have specific concerns about your **comfort** during dental treatment? ☐ *Yes* ☐ *No*
    If so, what? ____

22. Are you satisfied with the appearance of your teeth? ☐ *Yes* ☐ *No*

3. What would you like to change about your smile? ____
5. How often do you brush and floss your teeth? ____________________________________
6. Do your gums bleed while cleaning? ☐ *Yes* ☐ *No*
7. Do your gums ever feel tender or swollen? ☐ *Yes* ☐ *No*
8. Have you had periodontal treatment? ☐ *Yes* ☐ *No* *When?* _________________________
9. Does food catch between your teeth? ☐ *Yes* ☐ *No*
10. Do you clench or grind your teeth? ☐ *Yes* ☐ *No*
11. Does your jaw ever feel tired or achy? ☐ *Yes* ☐ *No*
13. Do you hear noises from the jaw joints? ☐ *Right* ☐ *Left* ☐ *Neither*
14. Does your jaw get “stuck”, “locked”, or “go out”? ☐ *Yes* ☐ *No*
15. Do you have pain in or around the ears or cheeks? ☐ *Yes* ☐ *No*
16. Do you have pain when chewing, yawning, or wide opening? ☐ *Yes* ☐ *No*
17. Does your bite feel uncomfortable or unusual? ☐ *Yes* ☐ *No* *How?* _________________________________
18. Have you previously been treated for a temporomandibular disorder (TMD)? ☐ *Yes* ☐ *No*
    If so, when, what treatment was done, how was it done, and by whom?
    ____

WELLNESS

24. Do you have any problems with sleep, such as:
    Insomnia: ☐ *Yes* ☐ *No* *Less than 7 hours a night:* ☐ *Yes* ☐ *No* *Sleep Disturbances:* ☐ *Yes* ☐ *No*
    Sleep Apnea: ☐ *Yes* ☐ *No* *Not refreshing or restful:* ☐ *Yes* ☐ *No* *Other:* ______________________________
25. Has anyone ever told you that you snore? ☐ *Yes* ☐ *No* *If so, is it bothersome to your bed partner?* ☐ *Yes* ☐ *No*
26. Do you experience fatigue during the day and have difficulty staying awake? ☐ *Yes* ☐ *No*
27. What is your stress level? ☐ *Mild* ☐ *Moderate* ☐ *Severe*
28. Do you have anxiety? ☐ *None* ☐ *Mild* ☐ *Moderate* ☐ *Severe*
29. Do you have trouble remembering things or paying attention during the day? ☐ *Yes* ☐ *No*
19. Have you ever had a sports injury, major or minor car accident, and/or trauma to your head or neck?
    ☐ *Yes* ☐ *No* *When and what?* ____
20. Do you experience pain in your:
    - *Shoulders:* ☐ *Right* ☐ *Left* ☐ *More than a year*
    - *Face:* ☐ *Right* ☐ *Left* ☐ *More than a year*
    - *Neck:* ☐ *Right* ☐ *Left* ☐ *More than a year*
    - *Jaw:* ☐ *Right* ☐ *Left* ☐ *More than a year*
    - *Arms:* ☐ *Right* ☐ *Left* ☐ *More than a year*
30. Do you wake up at night or in the morning with headaches? ☐ *Yes* ☐ *No*
31. How often do you get severe headaches/migraines that make it hard to function without treatment/medication?
    ☐ *Never* ☐ *Occasionally* ☐ *More than twice a year* ☐ *More than twice a month* ☐ *More than once a week*
32. How often do you get the less severe headaches?
    ☐ *Daily* ☐ *More than 3 per week* ☐ *More than 2 per month* ☐ *Other* __________________
33. How many days a month are you: *Pain free?* ___________________ *Headache free?* ____________________

Dental Insurance Carrier ____________________________________ Phone Number __________________________

Primary Insured ___________________________ Insured ID _____________________ Date of Birth _____________

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

This is to certify that I understand, consent to the performance of any and all dental procedures, and the use of any and all drugs that are agreed to be necessary or advisable. I also agree to accept full responsibility for the payment of fees associated with those procedures and all costs incurred in the collection of those fees. I understand there may be a 1.5% per month charge or a $25.00 rebilling fee (whichever is greater) on an unpaid balance over 30 days or older, unless other specific arrangements have been made.

Patient signature (Parent or Guardian) Date