PATIENT INFORMATION AND HEALTH HISTORY

We are complimented that you have selected us to provide for your dental care. Please complete this patient information and medical / dental health history form. (This information is necessary for our files and will be considered confidential.)

Purpose of Visit _____ **Date** _____

Patient's Name _____ **Birthday** _____ **Age** _____

Patient is: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed ❑ Minor ❑ Clergy

If student, name of school: _____ **City** _____ **State** _____

Name you prefer: _____ **Day Phone: ( )** _____ **Cell Phone:( )** _____

Patient's residence: _____
STREET CITY ZIP

Social Security No. _____ **Driver's License No**. _____ **E-mail:** _____

Employed by: _____ **How Long?** _____ **Occupation**: _____

Bus. Address: _____ **Bus. Phone ( )** _____ **EXT** _____
STREET CITY ZIP

Financially responsible person _____ **Relationship** _____

Responsible person's residence _____
STREET CITY STATE ZIP

Date of birth ___/____/_____ **Cell Phone ( )** _____ **Bus. Phone ( )** _____ **EXT** _____

Driver's License No. _____ **Social Security #** _____ **E-mail** _____

Employed by: _____ **How Long?** _____ **Occupation**: _____

Business Address _____
STREET CITY ZIP

Spouse's Name _____ **Soc. Sec. No**. _____

Employed by _____ **How Long?** _____ **Occupation** _____

Business Address _____ **Day. Phone** ( ) _____
STREET CITY ZIP

Name of nearest relative not living with you _____ **Relationship** _____

Complete Address _____ **Eve. Phone** ( ) _____
STREET CITY ZIP

Name of Physician _____
ADDRESS CITY TELEPHONE

Name of Dentist _____
ADDRESS CITY TELEPHONE

Who may we thank for referring you? _____

PLEASE COMPLETE ALL 4 PAGES

Medical History

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health.

Yes No Are you in good health? Date of last physical examination _____

Yes No Do you use tobacco products? _____

Yes No Are you now under the care of a physician?
If so, what is the condition being treated? _____

Yes No Have you ever had any serious illness or operation?
If so, what illness or operation? _____

Yes No Have you ever been hospitalized?
If so, what was the problem? _____

Yes No Are you taking any medications? ❑ **Check box if you are listing your medications on a separate sheet.**
If so, what? _____ What dosage? _____

Yes No Have you ever been pre-medicated with antibiotics for your dental treatment? _____

Yes No Are you sensitive or allergic to any drugs? ❑ Penicillin ❑ Tetracycline ❑ Sulfa drugs ❑ Aspirin
❑ Codeine ❑ Other If other, what drugs? _____

Yes No Do you wear a cardiac pacemaker, or have you had heart surgery? Year _____

Yes No Do you have any disease, condition or problem not listed that you think I should know about?
If so, what? _____

Yes No (Women) Are you pregnant? If so, how many months? _____

Yes No (Women) Do you take birth control pills? _____

Yes No Have you ever had any unfavorable reaction from a local anesthetic? _____

Yes No Do you snore or have difficulty sleeping? _____

Do you now have or have you had any of the following: (Please check ✓ known conditions)

❑ Anemia	❑ Hemophilia	❑ Drug Addiction	❑ Nervous Disorders	❑ Sickle Cell Disease
❑ Herpes	❑ Rheumatism	❑ Kidney Disease	❑ Tumors or Growths	❑ Tuberculosis (T.B..)
❑ Stroke	❑ Heart Murmur	❑ Stomach Ulcers	❑ Allergies or Hives	❑ Epilepsy or Seizures
❑ Diabetes	❑ Bruise Easily	❑ Angina Pectoris	❑ Cortisone Medicine	❑ Artificial Prosthesis
❑ Glaucoma	❑ Head Injuries	❑ Mental Disorder	❑ Excessive Bleeding	❑ Psychiatric Treatment
❑ Arthritis	❑ Heart Failure	❑ Rheumatic Fever	❑ Asthma	❑ Congenital Heart Lesions
❑ Cold Sores	❑ Liver Disease	❑ Thyroid Disease	❑ High Blood Pressure	❑ Emphysema
❑ Hay Fever	❑ Sinus Trouble	❑ Cerebral Palsy	❑ Latex Allergy	❑ Blood Disease
❑ Heart Ailments or Attack		❑ Joint Replacement	❑ Respiratory Disease	❑ Fainting Spells or Seizures
❑ Osteoporosis		❑ Radiation Treatment of any kind		❑ X-Ray or Cobalt Treatment
❑ Hepatitis or Jaundice		❑ Venereal Disease (Syphilis, Gonorrhea)		
❑ HIV (Human Immunodeficiency virus)			❑ Chemotherapy (Cancer, Leukemia)	
❑ Other _____				

❑ To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or if my medications change, I will inform the doctor at my next appointment without fail.

Date_____ **Signature** _____

Update 2nd year Changes in Health _____

_____ **Date**_____ **Signature** _____

Update 3rd year Changes in Health _____

_____ **Date**_____ **Signature** _____

Health Questionnaire MUST be updated every year!

PLEASE COMPLETE ALL 4 PAGES

Dental History

How long has it been since your last dental examination? _____

Complete mouth x-ray? _____ Dental Prophylaxis? _____

Yes No Have you had orthodontic treatment?
If YES, when? _____

Yes No Do you have unreplaced missing teeth?
If YES, why haven't you had them replaced? _____ Was it ever suggested? _____

Yes No Do your gums bleed when brushing your teeth?

Yes No Have you ever been told that you have periodontal disease (pyorrhea, gum disease)?

Yes No Have you ever had professional instructions on dental home care?

Yes No Is any part of your mouth sensitive to **temperature** or **pressure**?
If YES, circle which. Where? _____

Yes No Does food catch between your teeth?
If YES, where? _____

Yes No Do you have any unpleasant odor or taste in your mouth?

Yes No Are you dissatisfied with your teeth or their appearance?

Yes No Do you always have something to be treated or required when you visit a dentist?

Yes No Do you feel that in the past you have required a lot of dental work?
If YES, has it been to replace previous dentistry or to repair a new decay? Replace__ New Decay__

Yes No Are you aware that dental decay is essentially a childhood disease, and that most tooth filling procedures are to replace broken fillings or temporary dentistry?

Dentures

Yes No Do any members of your family, including your parents, wear dentures?

How long have you worn dentures?_____

How many dentures do you wear? _____

How many dentures have you worn? Upper _____ Lower _____

Why were your teeth extracted? _____

If you are currently having a denture problem, is it related to:
Pain _____ Discomfort _____ Appearance _____ Function _____

If you are a candidate for new or replacement dentures, how do you feel about getting dentures?

_____

Other Doctors

Your prior medical and dental experiences are of great value to us in assessing your present problem and determining to whom you would like to be referred should specialized care be required. Please list names of the following health care professionals who have or are now caring for you.

_____	_____	_____
GENERAL DENTIST	PROSTHODONTIST	PERSONAL PHYSICIAN
_____	_____	_____
ENDODONTIST	ORAL SURGEON	ORTHODONTIST
_____	_____	_____
PERIODONTIST	OTHER	OTHER

PLEASE COMPLETE ALL 4 PAGES

Occlusal Screening

Yes **No** Do you clench or grind your teeth during the day?

Yes **No** Have you been made aware of clenching or grinding your teeth during the night?

Yes **No** Do you have chronic headaches or neck and shoulder pains?

Yes **No** Do you ever awaken with an awareness about your teeth or jaw like you have had them clenched in your sleep?

Yes **No** Do you have any awareness (tightness, stiffness, pain) of the muscles in your neck or shoulders?

Yes **No** Do you now have, or have you ever had, pain in your jaw joint or the sides of your face?

Yes **No** Do you have any pain or soreness about your eyes? Right Left (Circle which)

Yes **No** Do you have a clicking jaw joint or have you ever experienced an inability to move your jaw or open your mouth widely?

Which side do you chew on? (Circle one): Right Left Both

Yes **No** Do you have difficulty swallowing?

Yes **No** Do you habitually bite your cheek, tongue or lip?

Yes **No** Do you play the violin, a wind instrument or do you snorkel or scuba dive?

Yes **No** Do you have recurring episodes of any of the following: (Please check ✓ those that apply.)

❑ Earache ❑ Ear congestion ❑ Loss of hearing acuity ❑ Tinnitus (ringing in the ears) ❑ Dizziness

Yes **No** Do you know the meaning of "traumatic occlusion"?

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent{s} to third–party insurance carriers, payors, and/or healthcare practitioners. I also consent to having information relative to my history, treatment and treatment outcome, collected and included in dental research and publications for scientific investigation and education provided my name is not revealed in said publication.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on the behalf of my dependents (if any).

Signature of patient, parent or guardian:_____

Relationship to Patient:_____ Date:_____

PATIENT PROVIDED TMJ HISTORY FORM In an effort to better care for your specific needs, we ask that you complete the separate two sided form if included in your packet.

PLEASE COMPLETE ALL 4 PAGES