# PATIENT HEALTH RECORD

Date _____

Dr. Mr. Mrs. Ms. _____ Spouses Name _____
(Last) (first) (initial)

Address _____
(Street) (city) (state) (zip code)

Home Phone (___)_____ Business Phone (___ )_____ E-Mail _____

Date of Birth _____ Sex M F Height _____Weight _____ Married _____ Single _____

Occupation _____ Social Security No. _____ - _____ - _____

Emergency Contact - Name _____ Phone Number (_____ ) _____

Whom may we thank for referring you to us? _____

MEDICAL HEALTH

What is your general state of health? Excellent _____ Good _____ Fair _____ Poor _____

Name and address and phone number of physician _____

_____

Have you been under a physician's care during the last two years? _____

Have you been treated in a hospital in the past three years? _____

Have you had major surgery? _____

History with general or IV anesthesia? _____

If female: Are you pregnant or nursing? _____

Do you or have you had any of the following?

Blood Pressure (office to take) _____

| | Past | Present | None | | Past | Present | None | | Past | Present | None |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Epilepsy or Seizures | ❑ | ❑ | ❑ | Kidney Problems | ❑ | ❑ | ❑ | Cancer | ❑ | ❑ | ❑ |
| Fainting or Dizziness | ❑ | ❑ | ❑ | Bruise/Bleeds easily | ❑ | ❑ | ❑ | Chemotherapy | ❑ | ❑ | ❑ |
| Stroke | ❑ | ❑ | ❑ | Heart Problem | ❑ | ❑ | ❑ | Radiation Therapy | ❑ | ❑ | ❑ |
| Persistent Cough | ❑ | ❑ | ❑ | Chest Pain/Angina | ❑ | ❑ | ❑ | Thyroid Disease | ❑ | ❑ | ❑ |
| Emphysema/Bronchitis | ❑ | ❑ | ❑ | High Blood Pressure | ❑ | ❑ | ❑ | AIDS/HIV+ | ❑ | ❑ | ❑ |
| Tuberculosis/PPD+ | ❑ | ❑ | ❑ | Rheumatic Fever | ❑ | ❑ | ❑ | Arthritis | ❑ | ❑ | ❑ |
| Asthma | ❑ | ❑ | ❑ | Heart Murmur | ❑ | ❑ | ❑ | Artificial Joints | ❑ | ❑ | ❑ |
| Sinus Problems | ❑ | ❑ | ❑ | Mitral Valve Prolapse | ❑ | ❑ | ❑ | Diabetes | ❑ | ❑ | ❑ |
| Anemia/Sickle Cell | ❑ | ❑ | ❑ | Congenital Heart Lesions | ❑ | ❑ | ❑ | Organ Transplants | ❑ | ❑ | ❑ |
| Hepatitis A, B, C | ❑ | ❑ | ❑ | Heart Surgery | ❑ | ❑ | ❑ | Osteoporosis/penia | ❑ | ❑ | ❑ |
| Liver Disease | ❑ | ❑ | ❑ | Artificial Heart Valves | ❑ | ❑ | ❑ | Snoring | ❑ | ❑ | ❑ |
| Pneumonia | ❑ | ❑ | ❑ | Pacemaker | ❑ | ❑ | ❑ | Sleep Apnea | ❑ | ❑ | ❑ |
| Nervousness/Anxious | ❑ | ❑ | ❑ | Fibromyalgia | ❑ | ❑ | ❑ | Dry Mouth | ❑ | ❑ | ❑ |
| Irregular Heart Beat | ❑ | ❑ | ❑ | Latex Allergy | ❑ | ❑ | ❑ | Tobacco Use | ❑ | ❑ | ❑ |

Do you have any condition, disease, or problem not previously listed? _____

_____

_____

Please list all the medications you are taking, including over the Counter Drugs and Herbs

| Medications: | Dosage: | Times/day | Medications | Dosage | Times/day |
|---|---|---|---|---|---|
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Are you allergic to: ❑ Penicillin, ❑ Codeine, ❑ Local Anesthetics, ❑Other _____

## DENTAL HEALTH

When was your last dental visit? _____ How often did you see your dentist? _____
Are you having any dental problems that require immediate attention? _____
Do you have frequent headaches? _____ Ear aches? _____ How often? _____
Is there anything that will cause your muscles to be tired or sore or cause headaches? _____
Are your jaw joints painful or tender? _____ If yes please describe _____
Have you had trauma to your jaw? _____ Do your jaw joints pop or click or grate? _____
Do your jaws ever feel tired or ache? _____ Have you ever been told you have TMJ? _____
Do you clench or grind your teeth? _____
Does your bite feel comfortable? _____ Have you noticed any change in your bite? _____
Have you ever been told you have periodontal disease? _____ Have you ever had periodontal treatment? _____
Do your gums bleed while cleaning? _____ Do your gums ever feel tender or swollen? _____
How often do you brush your teeth? _____ Floss? _____ Water Jet? _____
Do any of the following cause tooth discomfort? Hot _____ Cold _____ Sweets _____ Chewing _____
Have you noticed any changes in your teeth? _____
Do you have loose teeth? _____ Worn teeth? _____ Broken or chipped teeth? _____ Food Traps? _____
Can you chew on both sides of your mouth? _____ Comfortably? _____
Do you lose fillings or break fillings? _____ Do you usually have cavities? _____
Have you ever had orthodontic treatment? _____ When? _____
Do you have any missing teeth? _____ Have they been replaced? _____
Do you have a Fixed bridge? _____ Removable partial? _____ Full dentures Dental Implants? _____
Are you comfortable with the replacement? _____ Please describe _____
_____
How do you feel about the appearance of your smile? _____
What improvements would you like to make in your mouth? _____
_____
Please add anything you feel is important: _____
_____
_____
_____

Signature _____ Date _____

# PERSONAL DENTAL NEEDS SURVEY

Name: _____

**Please rate on a scale of 1-5 the importance of each of the following regarding your dental care. (The most important would be #1.)**

___ Preventive Dental Health care
___ Excellence and Quality of service
___ Other_____
___ Freedom from pain.
___ Cost and Affordability

**Please rate, as above, what a dentist has to do to gain your confidence.**

___Show me what he/she is doing or needs to do so I can clearly understand what is happening.
___Listen to my concerns and explain thoroughly the procedures to be performed.
___Make sure I feel comfortable and informed at all times.

**Please circle the level of fear you have about your dental visits. (10 being the greatest fear.)**
1 2 3 4 5 6 7 8 9 10

**I would like to know about these options available to me for maximizing my comfort and my experience during my visit. (Check all that apply.)**

___Music and earphones (Please list the type of music)_____
___Nitrous Oxide
___Sedative medications
___ Patient education materials

**Are you concerned about the following? (Yes or No):**

_____Existing discomfort?
_____Replacing old silver fillings?
_____Recurring or untreated gum disease?
_____Mouth odor?
_____Whitening your teeth?
_____Appearance of my smile?
_____Prevention of decay?
_____Other_____

**PLEASE CIRCLE ONE:**

**When discussing my treatment plan, I prefer:**

THE BIG PICTURE DETAIL BY DETAIL

**When evaluating my smile, it's most important:**

WHAT I SEE WHAT OTHERS SEE

## HIPAA CONSENT

By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, payment activities and health care operations. It also confirms that you have received a copy of our Notice of Privacy Practices.

Signature _____ Date _____