Patient Health Evaluation Patient Registration & Medical/Dental Health Evaluation

PATIENT INFORMATION	N
Date	
Patient Name	
Preferred Name	
Address	
City	
State Zip	
Email	SSN#
Sex M F	
Age Birth date	
\square Married \square Widowed \square Single	☐ Minor
☐ Separated ☐ Divorced ☐ Partner	red
Patient Employer/School	
Occupation	
Employer/School Address	
Spouse's Name	
Spouse Employer Occup	
Pharmacy NamePho	one
Whom may we thank for referring you?	
Please check the way you heard about us:	
☐ TV ☐ Radio ☐ Family/Friend	
□ Location □ Print Ad □ Other	

PHONE NUMBERS	8
Home	Cell
Work	Ext
Best Time & Place to reach you	
Spouse's Work Phone	
Spouse's Cell Phone	
In case of emergency Contact: (Sp	ecify someone not in household)
Name	
Relationship	
Home Phone	
Cell Phone	
Work Phone	

HEALTH HISTORY MEDICAL HISTORY	
HEALITI HISTORI MEDICAL HISTORI	
Physician's Name	
Phone	
Are you under a physicians care now? ☐ Yes ☐ No	
For what condition(s) are you being treated?	
	-
Date of last Visit Reason for Visit	-
Date of last Physical	

Date of Eval:	Dr/Hyg:
Place a mark on "Yes" or "No" to indicate of	you have or have had any of the following
Heart Angina/Chest Pain	□ Yes □ No
Artificial Valves	☐ Yes ☐ No
Congestive Heart Failure	☐ Yes ☐ No ☐ Yes ☐ No
Congenital Heart Disorder Heart Attack/Failure	☐ Yes ☐ No
Heart Murmur	□ Yes □ No
Heart Trouble/Disease	□ Yes □ No
Irregular Heart Beat Mitral Valve Prolapse	☐ Yes ☐ No ☐ Yes ☐ No
Pace Maker	□ Yes □ No
Other	E V. E N
Advised to take Pre-Med Antibiotics If yes, what Antibiotics?	□ Yes □ No
Prior to Dental TX: ☐ Yes ☐ No	Reason for Premed:
Vascular	
High Blood Pressure Baseline	☐ Yes ☐ No
Stroke	□ Yes □ No
Take blood thinners? Type	
Blood Transfusion When	□ Yes □ No
Excessive Bleeding	□ Yes □ No
ExplainBlood Disease	□ Yes □ No
Bruise Easily	□ Yes □ No
Daily Aspirin	☐ Yes ☐ No
Other	
Pulmonary	□ Vee □ Ne
Asthma Inhaler	☐ Yes ☐ No ☐ Yes ☐ No
If yes, where do you carry in case of	of emergency
Shortness of Breath / Easily Winded Sinus Trouble	☐ Yes ☐ No ☐ Yes ☐ No
Breathing Problems	☐ Yes ☐ No
Emphysema	□ Yes □ No
Fainting / Dizziness Other	☐ Yes ☐ No
Other	
Cancer	
Type: Date(s):	
Types of Treatment: ☐ Surgery	☐ Chemo ☐ Radiation
Infectious Disease	
Hepatitis A	☐ Yes ☐ No
Hepatitis B or C Tuberculosis	☐ Yes ☐ No ☐ Yes ☐ No
AIDS/HIV	□ Yes □ No
Other Systems	
Anemia Arthritis (Type)	☐ Yes ☐ No ☐ Yes ☐ No
Diabetes	
☐ Uncontrolled	□ Yes □ No
☐ Controlled by	□ Yes □ No □ Yes □ No
Kidney Disease Depression/Psychiatric Care (Circle)	□ Yes □ No
Seizure Disorder	□ Yes □ No
Type	
Date of Last Seizure	
Precipitating Factors	□ Yes □ No
Alzheimer's Disease Joint Replacement	☐ Yes ☐ No
Knee / Hip / Other Premed	
If yes, what Antibiotics?	
Doctor	_ Date of Surgery:
Type: Past Complica:	☐ Yes ☐ No
Type: Past Complicate Gastric Reflux/GERD/Consistent Hea	
Special Diet	☐ Yes ☐ No
Explain	· ·
Drug Addiction Past / Present (circle)	□ Yes □ No
Recreational Drug Use within Past 3	Years □ Yes □ No

Scanned: __

(Office Use Only)

Medications			E. Gum and Bone			
List any Medications you are currently takin	g & Correlating	Reason:	Have you been Diagnosed or treated for periodonta	al (gum c	or bo	ne)
(Provide Separate list if necessary)			disease? □ Yes □ No			
(i. iothas coparate net ii iiocossa.)			Explain			
				☐ Yes	П	No
				□ Yes		
			Smoke / Chewing Tobacco (circle)	_ 100		110
			How often? when did you star	t?		
			Have you considered Stopping?	□ Yes		No
Allergies			Unpleasant taste or odor in your mouth?	□ Yes		No
☐ Aspirin ☐ Codeine ☐ Latex ☐ Local	Anesthetic \square	Antibiotics	Mouth odor / Bad taste / Bad breath (circle)			
□ Other			3, 111 3	☐ Yes		
				☐ Yes☐ Yes		No No
Women:				☐ Yes		
Are you pregnant presently?	□ Yes	□ No	Gum Recession (shrinking)? ☐ Unsure			
Due Date			Mouth Breath (awake or asleep)? ☐ Unsure	□ Yes		No
Trying to get pregnant	□ Yes	□ No	Snore □ Unsure	□ Yes		No
Taking oral contraceptives	☐ Yes	□ No	Cold sores/fever blisters on lips or mouth?	□ Yes		No
Nursing	☐ Yes	□ No	Location			
			Frequency			
			Meds previously used			
DENTAL HISTORY			F. Bite and Jaw Joint			
A. Reason for today's visit & your immed	iate concern		Clench? Day / Night (circle) ☐ Unsure I	□ Yes		No
74 Nousen for Loudy & Viole & your miniou	_		Grind? Day / Night (circle) ☐ Unsure I	□ Yes		No
			Tired Jaws? ☐ Yes ☐ No Especially in A.M?	□ Yes		No
			Have you ever had your Bite adjusted?	□ Yes		No
List all current dental problem(s) concern(s)		(3.2.3)	☐ Yes		No
				☐ Yes		No
			F-F 3-	□ Yes		No
			(-)	☐ Yes		
Tooth Sensitivity:				☐ Yes☐ Yes		
□ Cold □ Pain □ Hot □ Sweets □	Swelling DA	che	Do you notice:	□ 162	_	NO
☐ Biting or Chewing				□ Yes		No
How would you rate the condition of your m	nouth?:		Difficulty chewing on either side of mouth?	□ Yes		No
☐ Excellent ☐ Good ☐ Fair ☐ Poor	☐ Unsure		G. Tooth Alignment			
B. Former/Previous Dentist			Previous orthodontic treatment (braces/invisalign)	□ Yes		No
Address			,	□ Yes		No
Date of Most Recent Exam/Cleaning			117	☐ Yes		No
Date of Most Recent treatment			·	□ Yes		No
What was performed?				□ Yes		No
In the past I have seen my dentist every	□ 3 mo □ 4	mo □ 6 mo	Location(s) Crooked/crowded?	□ Yes		No
	□ 12 mo □ r	not routinely		☐ Yes		No
C. Personal Dental History:		,		□ Yes		
Are you fearful of Dental Treatment?	☐ Yes	□ No	•	□ Yes		No
Upsetting dental experience? ☐ Yes ☐ No				□ Yes		No
			H. Smile			
Complications with previous dental treatment			Desire to learn more about options to enhance sr	mile? □	Yes	□ No
Back problems/difficulty sitting in dental chair			Explain:			
Unusual bleeding with previous dental treatm						
Have you had trouble getting Numb or Reac			Concern with color of teeth/smile ☐ Yes ☐ No If	yes, exp	lain_	
Explain			Have you ever considered whitening	□ Yes	П	No
			riave you ever considered whitefully	<u>п 162</u>	_	NO
D. Home Care	nin Devet C.C.	o ob over a skill				
Type of toothbrush: ☐ Regular ☐ Battery S	•	-	Patient Signature:			
Type of ToothpasteWhen/How often do you Brush?			-			
When/How often do you Floss?						
Do you brush or scrape your tongue?			Scanned:(Of	ffice Use	On	ly)
			(5.			



Please take a moment to observe your teeth carefully and answer the questions below. Your response enables us to understand your expectations and concerns about your dental health.

1.	On a scale of 1 to 10, how do you feel about your teeth and smile? 1 meaning you don't like anything, 10 meaning everything is great!
2.	Are you concerned about the color of your teeth?
3.	Do you like the shape of your teeth?
4.	Do you have spaces that you don't like?
5.	Are your teeth all in alignment? Straight? Crooked? Crowded?
6.	Are your teeth chipped? Protruding? Hidden?
7.	Are there old fillings or dental work you don't like looking at?
8.	Is there anything about the appearance of your teeth that you would like to change?
9.	Tell us about your smile. Do you like the appearance of your teeth?
10.	How would you like your teeth to look?
11.	Have you been disappointed with the appearance of previous dental work? Please explain