

Patient Health Evaluation

Patient Registration & Medical/Dental Health Evaluation

1

PATIENT INFORMATION

Date _____

Patient Name _____

Preferred Name _____

Address _____

City _____

State _____ Zip _____

Email _____ SSN# _____

Sex M F

Age _____ Birth date _____

Married Widowed Single Minor

Separated Divorced Partnered

Patient Employer/School _____

Occupation _____

Employer/School Address _____

Spouse's Name _____

Spouse Employer _____ Occupation _____

Pharmacy Name _____ Phone _____

Whom may we thank for referring you? _____

Please check the way you heard about us:

TV Radio Family/Friend

Location Print Ad Other _____

2

PHONE NUMBERS

Home _____ Cell _____

Work _____ Ext _____

Best Time & Place to reach you _____

Spouse's Work Phone _____

Spouse's Cell Phone _____

In case of emergency Contact: *(Specify someone not in household)*

Name _____

Relationship _____

Home Phone _____

Cell Phone _____

Work Phone _____

3

HEALTH HISTORY MEDICAL HISTORY

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 if you have or have had any of the following:

Heart

Angina/Chest Pain Yes No

Artificial Valves Yes No

Congestive Heart Failure Yes No

Congenital Heart Disorder Yes No

Heart Attack/Failure Yes No

Heart Murmur Yes No

Heart Trouble/Disease Yes No

Irregular Heart Beat Yes No

Mitral Valve Prolapse Yes No

Pace Maker Yes No

Other _____

Advised to take Pre-Med Antibiotics Yes No

If yes, what Antibiotics? _____

Prior to Dental TX: Yes No Reason for Premed: _____

Vascular

High Blood Pressure Yes No

Baseline _____

Stroke Yes No

Take blood thinners? Type _____

Blood Transfusion Yes No

When _____

Excessive Bleeding Yes No

Explain _____

Blood Disease Yes No

Bruise Easily Yes No

Daily Aspirin Yes No

Other _____

Pulmonary

Asthma Yes No

Inhaler Yes No

If yes, where do you carry in case of emergency _____

Shortness of Breath / Easily Winded Yes No

Sinus Trouble Yes No

Breathing Problems Yes No

Emphysema Yes No

Fainting / Dizziness Yes No

Other _____

Cancer

Type: _____

Date(s): _____

Types of Treatment: Surgery Chemo Radiation

Infectious Disease

Hepatitis A Yes No

Hepatitis B or C Yes No

Tuberculosis Yes No

AIDS/HIV Yes No

Other Systems

Anemia Yes No

Arthritis (Type) _____ Yes No

Diabetes Yes No

Uncontrolled Yes No

Controlled by _____ Yes No

Kidney Disease Yes No

Depression/Psychiatric Care (Circle) Yes No

Seizure Disorder Yes No

Type _____

Date of Last Seizure _____

Precipitating Factors _____

Alzheimer's Disease Yes No

Joint Replacement

Yes No

Knee / Hip / Other _____ Premed Needed? Yes No

If yes, what Antibiotics? _____

Doctor _____ Date of Surgery: _____

Thyroid Disease

Yes No

Type: _____ Past Complications _____

Gastric Reflux/GERD/Consistent Heart burn Yes No

Special Diet Yes No

Explain _____

Drug Addiction Yes No

Past / Present (circle)

Recreational Drug Use within Past 3 Years Yes No

Scanned: _____

(Office Use Only)



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? _____
Is this a concern? _____
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. _____
