PATIENT HEALTH RECORD

Dr David R Smith, D.D.S.
1707 S Oneida St • Appleton, WI 54915 • 920-734-2392

NAME _____ DATE _____
(LAST) (M) (FIRST)

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE (Home) _____ (Business) _____

DATE OF BIRTH _____ SEX: M ❑ F ❑

EMPLOYER _____

MARITAL STATUS (circle) SINGLE MARRIED WIDOWED DIVORCED

SPOUSE'S NAME _____

NAME OF DENTAL INSURANCE (if applicable) _____

POLICYHOLDER _____ EMPLOYER _____

POLICYHOLDER SS # _____ GRP # _____

REFERRED BY _____

REASON FOR YOUR VISIT _____

EMERGENCY INFORMATION: NAME, ADDRESS AND TELEPHONE OF AN INDIVIDUAL WE CAN CALL.

_____

_____

MEDICAL HEALTH

General health (please check): Excellent ❑ Good ❑ Fair ❑ Poor ❑

Name and address of your physician _____

_____

Last complete physical? _____

Are you presently under the care of a physician? ..... ❑ Yes ❑ No

If so, for what reason? _____

_____

Are you taking any medication now? ..... ❑ Yes ❑ No

If yes, please list all medications. _____

_____

Are you allergic to: Antibiotics ❑ Latex ❑ Codeine ❑
Aspirin ❑ Local Anesthetics ❑

Or any other medications? _____

Have you ever been hospitalized: If so, give reason and dates.

_____

_____

Have you had any radiological diagnostic x-rays in the last five years? ..... ❑ Yes ❑ No

Have you had any blood transfusions? ..... ❑ Yes ❑ No

Are you currently trying to modify your weight? ..... ❑ Yes ❑ No

Do you take any medications to help in weight reduction? ❑ Yes ❑ No

Do you smoke cigarettes? ..... ❑ Yes ❑ No

How many per day? _____

Do you consume alcohol? ..... ❑ Yes ❑ No

If yes, how much per week? _____

Is your blood pressure: Normal ❑ Low ❑ High ❑

Have you experienced any recent weight change? ..... ❑ Yes ❑ No

Women: Are you pregnant? ..... ❑ Yes ❑ No

Are you taking oral contraceptives? ..... ❑ Yes ❑ No

Do you have or any you ever been informed that you had any of the following:

Chest Pains	❑ Yes	❑ No	Epilepsy or Seizures	❑ Yes	❑ No	Persistent Cough	❑ Yes	❑ No
Heart Disease	❑ Yes	❑ No	Anemia	❑ Yes	❑ No	Prolonged Bleeding Problems	❑ Yes	❑ No
Rheumatic Fever	❑ Yes	❑ No	Cancer or Leukemia	❑ Yes	❑ No	Sexually Transmitted Diseases:	❑ Yes	❑ No
Congential Heart Defects	❑ Yes	❑ No	Psychiatric Problems	❑ Yes	❑ No	(Gonorrhea, Syphilis, Genital Herpes)		
Heart Murmur	❑ Yes	❑ No	Anxiety Disorders	❑ Yes	❑ No	Genetic Problems	❑ Yes	❑ No
Fainting Spells	❑ Yes	❑ No	Eating Disorders	❑ Yes	❑ No	Skin Disease	❑ Yes	❑ No
Hypertension	❑ Yes	❑ No	Glaucoma	❑ Yes	❑ No	AIDS	❑ Yes	❑ No
Kidney Problems	❑ Yes	❑ No	Prosthetic Valves or Joints	❑ Yes	❑ No	Unexplained Fevers	❑ Yes	❑ No
Stroke	❑ Yes	❑ No	Bruise Easily	❑ Yes	❑ No	Prolonged Sore Throat	❑ Yes	❑ No
Thyroid Problems	❑ Yes	❑ No	Asthma or Hay Fever	❑ Yes	❑ No	Enlarged Lymph Nodes	❑ Yes	❑ No
Hormonal Problems	❑ Yes	❑ No	Allergies or Hives	❑ Yes	❑ No	Night Sweats	❑ Yes	❑ No
Ulcers	❑ Yes	❑ No	Sinus Trouble	❑ Yes	❑ No	Bluish-Reddish Lesions	❑ Yes	❑ No
Lung Disease	❑ Yes	❑ No	Arthritis	❑ Yes	❑ No	Fatigue	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No	Excessive Urination and/or Thirst	❑ Yes	❑ No			

DENTAL HEALTH

When was your last dental visit? _____

Have you ever had any serious problems associated with previous dental treatment? ❑ Yes ❑ No

If yes, explain: _____

How often do you brush your teeth? _____

How often do you floss? _____

Do you routinely use a mouth rinse? ❑ Yes ❑ No

How many per day? _____

Do you experience dry mouth (Xerostomia)? ❑ Yes ❑ No

Do your gums bleed while brushing and/or flossing? ❑ Yes ❑ No

Do you avoid brushing any part of your mouth because of pain or sensitivity? ❑ Yes ❑ No

Do you feel twinges of pain when your teeth come in contact with hot, cold, sweet or sour? ❑ Yes ❑ No

Are any of your teeth sensitive to air or during chewing? ❑ Yes ❑ No

What texture brush do you use? Soft ❑ Medium ❑ Hard ❑

Do you chew on only one side of your mouth? ❑ Yes ❑ No

Does food catch between your teeth? ❑ Yes ❑ No

Do you feel your teeth are affecting your health in any way? ❑ Yes ❑ No

Have you ever had professional advice in dental home care? ❑ Yes ❑ No

Do you clench or grind your teeth while sleeping or during the day? ❑ Yes ❑ No

Do your facial muscles ever feel tired or the joints near your ears pop or click? ❑ Yes ❑ No

Do you wear full dentures? Upper ❑ Lower ❑

Do you wear partial dentures? Upper ❑ Lower ❑

Do you have retention problems with your full or partial dentures? ❑ Yes ❑ No

Do you gag easily? ❑ Yes ❑ No

Are you apprehensive (nervous) about your dental treatment? ❑ Yes ❑ No

If yes, have you had: Nitrous Oxide ❑ Medication prior to treatment ❑

Please add anything you feel is important. _____

_____

Are there any other health issues not mentioned above? ❑ Yes ❑ No

If yes, please explain. _____

Have you ever been told you need Pre-Medication for dental procedures? ❑ Yes ❑ No

Have you ever been tested for Hepatitis? ❑ Yes ❑ No

Do you have a history of cold sores, fever blisters, or canker sores? ❑ Yes ❑ No

Are you being treated with immunosuppressive drugs? ❑ Yes ❑ No

Have you ever used drugs for receational purposes in the last 5 years? ❑ Yes ❑ No

CONSENT:

The undersigned hereby authorizes Doctor, after consulting with patient, to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient) _____ and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents, dental procedures and materials embodies a certain risk. I understand that responsibility for payment of Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made.

_____

PATIENT SIGNATURE DATE