Szmanda
Dental Center

PATIENT INFORMATION AND HEALTH HISTORY

Today's Date: ____________________

Patient Name: ______________________ ☐ Single ☐ Married ☐ Divorced ☐ Separate ☐ Widowed

Date of Birth: ______________________ E-mail: ______________________

Patient Address: ____
Street City/State Zip Code

Home Phone: ____________ Cell Phone: ____________ Work Phone: ____________

Employer: ____________________ Social Security No.: ____________________

Dental Insurance Carrier: ____________________ Insurance No.: ____________________

Hobbies (Interests): ____

Spouse Name (If married, otherwise responsible party): ________________ Spouse Date of Birth: __________

Spouse Employer: ____________________ Spouse Work Phone: ____________________

Spouse Dental Insurance Carrier: ________________ Insurance No.: ________________

Spouse Social Security No.: ______________

DENTAL HISTORY

Date of last dental exam (approximate): ______________

Previous dentist's name: ______________________ City: ____________________

Do you have any problems in your mouth now? ☐ Yes ☐ No

Do you feel nervous about having dental treatment ☐ Yes ☐ No Explain ______________

Have you ever had a bad experience in the dental office? ☐ Yes ☐ No Explain ____________

Check any of the following which you experience:

- ☐ Teeth sensitive to cold, heat, sweets or pressure
- ☐ Bleeding gums How long: ____________
- ☐ Food impaction
- ☐ Clenching or grinding
- ☐ Burning of tongue
- ☐ Swelling or lumps in mouth
- ☐ Frequent blisters on lips or mouth
- ☐ Pain around ear
- ☐ Unusual sounds in ear while eating
- ☐ Bad breath
- ☐ Unpleasant taste
- ☐ Complications from extractions
- ☐ Periodontal treatment
- ☐ Orthodontic treatment
- ☐ Mouth breathing
- ☐ Oral habits, *i.e., fingernail biting, cheek biting, etc.*

Check any of the following that you use:

- ☐ Cigarettes, pipe or cigar smoking
- ☐ Texture of toothbrush: ☐ Hard ☐ Soft
- ☐ Brushing: ______/day
- ☐ Dental Floss
- ☐ Inter dental stimulators
- ☐ Water jet device
- ☐ Disclosing tablets or solution
- ☐ Fluoride supplements

CONTINUED ON REVERSE

Szmanda
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PATIENT INFORMATION AND HEALTH HISTORY

Present Physician: ______________________________ Phone Number: _________________________

Are you having any health concerns at this time? ☐ Yes ☐ No
Explain: ____

Have you been a patient in the hospital during the past two years? ☐ Yes ☐ No
Explain: ____

Have you been under the care of a medical doctor during the past two years? ☐ Yes ☐ No
Explain: ____

Have you ever had any excessive bleeding requiring special treatment? ☐ Yes ☐ No
Explain: ____

Are you allergic to *(i.e., itching, rash, swelling of hands, feet or eyes)* or made sick by penicillin, aspirin, codeine, latex, or any drugs or medications? ☐ Yes ☐ No Explain: ______________________________

Have you taken any medicines or drugs during the past two years? ☐ Yes ☐ No
Explain: ____

Did you take or are you currently taking any bisphosphonates? Generic brand examples: **alendronate, ibandronate, risedronate, zoledronic acid**, Brand Name examples: **Fosamax, Boniva, Actonel, Atelvia, Reclast**

Check any of the following which you have had or have at present:

- ☐ Heart Failure
- ☐ Heart Disease or Attack
- ☐ Angina Pectoris
- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ Rheumatic Fever
- ☐ Congenital Heart Lesions
- ☐ Scarlet Fever
- ☐ Artificial Heart Valve
- ☐ Heart Pacemaker
- ☐ Heart Surgery
- ☐ Artificial Joint
- ☐ Arthritis
- ☐ Anemia
- ☐ Stroke
- ☐ Kidney Trouble
- ☐ Ulcers
- ☐ Parkinson's Disease
- ☐ Bruise Easy
- ☐ Emphysema
- ☐ Cough
- ☐ Tuberculosis (TB)
- ☐ Asthma
- ☐ Hay Fever
- ☐ Sinus Trouble
- ☐ Allergies or Hives
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ X-ray or Cobalt Treatment
- ☐ Chemotherapy (Cancer, Leukemia)
- ☐ Cold Sores
- ☐ Rheumatism
- ☐ Cortisone Medicine
- ☐ Glaucoma
- ☐ Pain in Jaw Joints
- ☐ Psychiatric Treatment
- ☐ Alcohol Addiction
- ☐ AIDS
- ☐ Hepatitis A (infectious)
- ☐ Hepatitis B (serum)
- ☐ Hepatitis C
- ☐ Liver Disease
- ☐ Yellow Jaundice
- ☐ Blood Transfusion
- ☐ Drug Addiction
- ☐ Hemophilia
- ☐ Venereal Disease (Syphilis, Gonorrhea)
- ☐ Genital Herpes
- ☐ Epilepsy or Seizures
- ☐ Fainting or Dizzy Spells
- ☐ Nervousness
- ☐ Sickle Cell Disease
- ☐ Other *please list:*
  ____
  ____

Do you need to take pre-medication for dental work due to having artificial joint or heart valve?
☐ Yes ☐ No If Yes, please state reasoning for pre-med: ______________________________

WOMEN: Are you pregnant now? ☐ Yes ☐ No If yes, how far along? ______________________
Are you presently taking oral contraceptives? ☐ Yes ☐ No Do you anticipate becoming pregnant? ☐ Yes ☐ No

The information on this page is correct to the best of my knowledge. I hereby authorize the dental office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. I also understand the use of anesthetic agents embodies a certain risk. The risks include, but are not limited to pain, swelling, bruising and permanent anesthesia. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

Date: ______ Signature: ________________________
Patient or Responsible Party

IN-OFFICE USE ONLY

____/____	________	______________	________
BP	P	Reviewed by	Date

MEDICAL UPDATES I have read my MEDICAL HISTORY and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	BP	REVIEWED BY
________	____________________	NONE ☐	____________________	____/____	____________
________	____________________	NONE ☐	____________________	____/____	____________
________	____________________	NONE ☐	____________________	____/____	____________
________	____________________	NONE ☐	____________________	____/____	____________