The Dental Equation

BRINGING VALUE & UNDERSTANDING TO DENTISTRY

Patient's Name: _____ Date of Birth: _____/_____/_____

(Please print)

Street Address**:** _____ Social Security #: _____-_____-_____

City, State, Zip: _____ Home Phone: (_____) _____-_____

E-Mail Address**:** _____Cell Phone: (_____) _____-_____

Sex: _ Female _ Male Preferred Pronoun_____

Marital Status: _ Married _ Single _ Divorced _ Separated _ Widowed

Name of Employer: _____Work Phone: (_____) _____-_____

Street Address, City, State, Zip: _____

STUDENT INFORMATION

Name of School: _____

((Please circle one): Part Time (Less than 12 units) - Full Time (More than 12 units)

Street Address, City, State, Zip:

_____

EMERGENCY CONTACT

Name: _____Phone #: (_____) _____-_____ Relationship: _____

GUARANTOR INFORMATION IF PATIENT IS A MINOR

Guarantor's Name: _____ Home Phone: (____) ____-_____

Address: _____

Name of Employer: _____ Work Phone: (____) ____-_____

If the patient's parents are separated, parent with whom the patient reside? Name

_____

Primary General Dentist: _____

Physician's name, address, and telephone number: _____

Patient *or* guarantor's signature: _____Date: _____

Primary Insurance

Name of Insurance: _____

Policy/Subscriber's Name: _____

Date of Birth: _____/_____ /_____

Social Security #: _____-_____-_____

Relationship to Patient: _____

ID#: _____

Group #: _____

Secondary Insurance

Name of Insurance: _____

Policy/Subscriber's Name: _____

Date of Birth: _____/_____ /_____

Social Security #: _____-_____-_____

Relationship to Patient: _____

ID#: _____

Group #: _____

Medical Insurance

Name of Insurance: _____

Policy/Sub's Name: _____ Date of Birth: _____/_____/_____

Relationship to Patient: _____ __ Social Security#: _____-_____-_____

ID#: _____ Group#: _____

Whom may we thank for referring you to our office? FB__ Google__ Family/Friend__ Doctor__

Other: _____

HEALTH HISTORY

Patient's Name _____ Date_____

Answer all questions by circling Yes (Y) or No (N) All responses are kept confidential

1. Are you in good health? .....Y N

2. Has there been any change in your general health in the past year?....'Y N

3. Date of last physical exam? _____

4. Are you now under a physician's care fora particular problem?.....Y N

5. Have you **ever** had any serious illnesses, operations or hospitalizations? If so, describe: .....Y N

_____

6. Height _____ Weight_____

7. **DO YOU HAVE OR HAVE YOU EVER HAD:**

A. Rheumatic Fever or Rheumatic Heart Disease? .....Y N

B. Congenital Heart Disease?.....Y N

C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?).....Y N

D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis,

Shortness of Breath, Chest Pain, Severe Coughing)?.....Y N

E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness .....Y N

F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily?.....Y N

G. Liver Disease (Jaundice, Hepatitis)?.....Y N

H. Kidney Disease? .....Y N

I. Diabetes? .....Y N

J. Thyroid Disease (Goiter)?.....Y N

K. Arthritis? .....Y N

L. Stomach Ulcers or Colitis? .....Y N

M. Glaucoma? .....Y N

N. Implants placed anywhere in your body or a joint replacement

(Heart Valve, Pacemaker, Hip, Knee)? .....Y N

If yes, date: _____

Are you planning any future joint replacement or implant placements? ……Yes:_____ No: _____

O. Radiation, chemotherapy, medications or any other form of treatment for Cancer? .....Y N

P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth?.....Y N

Q. Sinus or Nasal problems?.....Y N

R. Any disease, drug or transplant operation that has depressed your immune system? .....Y N

8. **ARE YOU USING ANY OF THE FOLLOWING:**

A. Antibiotics? .....Y N If yes, reason: _____

B. Anticoagulants (Blood Thinners)? .....Y N

C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? ……..Y N If yes, how often? _____

D. High Blood Pressure? .....Y N

E. Steroids (Cortisone, etc.)? .....Y N

F. Tranquilizers?.....Y N

G. Insulin or Oral Anti-Diabetic drugs?.....Y N

H. Digitalis, Inderal, Nitroglycerin or other heart drug?.....Y N Other: _____

I. Please list any and all medications taken, including prescription medications, over-the-counter medications, herbal or holistic remedies, vitamins or minerals:_____

_____

9. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**

A. Local Anesthesia (Novocain, etc.)?.....Y N

B. Penicillin or other antibiotics? .....Y N Yes, other:_____

C. Sedatives, Barbiturates?.....Y N

D. Aspirin or Ibuprofen?.....Y N

E. Codeine or other pain killers?.....Y N Yes,other: _____

F. Latex or Rubber Products?.....Y N

G. Other allergies or reactions? Please, list.....Y N _____

Lifestyle:

10. Do you smoke (hookah, cigarettes, electronic cigarettes or chew Tobacco?....Y N How much per day?

_____

11. Any past history of Alcohol Abuse or Drug Dependency or Emotional Disorder? ……Y N
Which one? _____

12. Have you had any serious problems associated with any previous dental treatment?.....Y N

_____

_____

13. Have you or an immediate family member had any problem associated with intravenous anesthesia?.....Y N

14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? _____

15. Do you play any sports ?.....Y N Which one? _____How often?_____

16. Have you ever been diagnosed with sleep apnea? .....Y N

17. Do you use a CPAP machine or were prescribed one? .....Y N

18. Do you snore or have been told that you do? .....Y N

If yes, how often do you snore? _____

19. Do you wake up in the middle of the night to use the restroom? .....Y N

20. Do you suffer for any sleep related disorder (sleep-walking, insomnia)? .....Y N

21. Do you have a deviated nasal septum? .....Y N

22. Do you suffer from chronic sinusitis or are under related specialized care (ENT, pulmonologist)? ...Y N

23. Do you wish to talk to the doctor privately about anything else? .....Y N

24. **FOR WOMEN ONLY**

A. Are you Pregnant, or **is <u>there any chance</u>** you might be Pregnant?.....Y N

B. Are you nursing or pumping? .....Y N

C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance. **I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Heath History with my doctor.**

Medical Update: I have read my Health History, dated, and confirm that it adequately states past and present conditions.

Date_____ Patient's Signature: _____

Doctor's Initials _____