Patient Health History

This personal information will help us to give you the most consideration of your time and feelings.
It is important to have complete answers. All of the information is, of course, confidential.

Date _____

PERSONAL INFORMATION

Your Name: _____ Date of Birth: _____

Home Address: _____ City _____ State, Zip _____

Home Phone: ( ) _____ Cell Phone: ( ) _____

Social Security No: _____ eMail: _____

Spouse Name: _____

Your Occupation: _____ **Spouse's Occupation:** _____

Company Name: _____ Company Name: _____

Work Phone: ( ) _____ Ext: _____ Work Phone: ( ) _____ Ext: _____

Are you covered by Dental Insurance? _____ If so, what company _____

May we ask who recommended you to this office? _____

MEDICAL HEALTH

Physician's name & address: _____ Phone ( ) _____

Have there been any problems in your general health in the past 5 years? _____

(Serious illness, hospitalization, surgery)

If so, what was the problem: _____

The date of your last medical check-up: _____ Are you under a physician's care now? _____

If so, for what _____

What tablets, pills, or liquids do you take (that includes aspirin, vitamins, tonics, etc.) _____

_____

DO YOU HAVE OR EVER HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS:

	YES	NO
Rheumatic Fever, Rheumatic heart Disease (circle)	_____	_____
If **YES**, do you need to be Premedicated with an Antibiotic	_____	_____
Heart trouble, Heart attack, High blood pressure	_____	_____
Stroke	_____	_____
Pacemaker	_____	_____
Stent	_____	_____
If **YES** where _____		
Pain in chest, shortness of breath, swollen ankles	_____	_____
Blood disorders, Anemia	_____	_____
Blood test with unusual results	_____	_____
Abnormal bleeding, Prolonged healing, Bruise easily	_____	_____
Asthma, Hay fever (circle)	_____	_____
Low Blood Pressure	_____	_____
Fainting spells, Seizures (circle)	_____	_____
Hepatitis A, B, or C, Jaundice, Liver disease (circle)	_____	_____
Arthritis	_____	_____
Kidney Trouble	_____	_____
Tuberculosis, other lung ailments	_____	_____
Aids or HIV positive	_____	_____
Thyroid	_____	_____
Diabetes	_____	_____
Radiation treatment for tumor or growth	_____	_____

	YES	NO
Any Prosthetic replacement	_____	_____
• if **YES**, do you need to be Premedicated with an Antibiotic	_____	_____
Sores that did not heal within 1 week	_____	_____
Women: Are you pregnant?	_____	_____
Sensitive or Allergic to:		
Penicillin	_____	_____
Codeine	_____	_____
Novocain	_____	_____
Aspirin	_____	_____
Epinephrine	_____	_____
Sulfa	_____	_____
Anesthetics _____	_____	_____
Other drugs _____	_____	_____

Tobacco User: Type/Amount _____

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

_____

_____

_____

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DENTAL HEALTH

Are you aware of any particular dental problems? _____

_____

Are you having any discomfort or pain? _____
How long since your last dental visit? _____
What was done at that time? _____
Have you ever had any serious problems associated with previous dental treatments? _____
If so explain: _____
How often do you brush your teeth? _____
What texture brush do you use? Soft____ Medium_____ Hard___ Natural_____
How often do you floss? _____

Do your gums bleed while brushing? Yes____ No_____
Do your gums bleed while flossing? Yes____ No_____
Do you avoid brushing any part of your mouth because of pain? Yes____ No_____
If yes, what part? _____
Do you feel twinges of pain when your teeth come in contact with:

- ❖ Hot foods or liquids, i.e., soup, coffee, tea, etc.? Yes____ No_____
- ❖ Cold foods or liquids, i.e., ice cream, cold fruit, etc.? Yes____ No_____
- ❖ Sweets, i.e., candy, fruit, sweet desserts. etc.? Yes____ No_____
- ❖ Sours, i.e., lemons, limes, grapefruit, etc.? Yes____ No_____

Do you feel pain to any of your teeth when brushing or flossing them? Yes____ No_____
Do you chew on only one side of your mouth? Yes____ No_____
If yes, explain: _____
Do your gums feel tender or swollen? Yes____ No_____
Do you clench or grind your jaw while sleeping or during the day? Yes____ No_____
Does your jaw ever feel tired? Yes____ No_____
Do you wear dentures? Yes____ No_____
Do you usually have many cavities? Yes____ No_____
Do you loose fillings or break fillings? Yes____ No_____
Do you gag easily? Yes____ No_____
Are you familiar with the term "Preventative Dentistry"? Yes____ No_____

Please add anything you feel is important: _____

_____

_____

_____

_____

_____

_____

I hereby give the office of Dr. Nancy Arndt permission for an Exam, Prophylaxis (cleaning) and X-rays if due.

Please note that there is a $25.00 charge on appointments that are either a "no show" or cancelled with less than a 24 hour notice. The charge is $50.00 broken Saturday appointments.

_____
(Patient signature)