

Patient Medical History

Patient Name: _____ Nickname: _____ Birthdate: _____

• Would you consider your general health to be Excellent Good Fair Poor

• When was your most recent physical examination: _____ Purpose: _____

• Primary Physician _____ Primary Physician's Specialty: _____

Do you or have you ever:	Yes	No	Do you or have you ever:	Yes	No
1. been hospitalized for injury or illness	<input type="checkbox"/>	<input type="checkbox"/>	24. diabetes	<input type="checkbox"/>	<input type="checkbox"/>
2. had an allergic reaction to:	<input type="checkbox"/>	<input type="checkbox"/>	25. digestive disorders (i.e. gastric reflux)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Aspirin, Ibuprofen, Acetaminophen			26. taking biphosphorates for osteoporosis/osteopenia	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Penicillin			27. glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Erythromycin			28. arthritis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Tetracycline			29. head or neck injuries	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Codeine			30. contact lenses	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Local Anesthetic			31. epilepsy, convulsions or seizures of any kind	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Flouride			32. alcohol or drug dependency	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Metals (gold, stainless steel)			33. antidepressant medication of any sort	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Latex			34. psychiatric treatment	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other medication (list) _____			35. emotional problems	<input type="checkbox"/>	<input type="checkbox"/>
3. had heart problems	<input type="checkbox"/>	<input type="checkbox"/>	36. chemotherapy or radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>
4. had heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	37. hepatitis (and type: _____)	<input type="checkbox"/>	<input type="checkbox"/>
5. had rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	38. subject to frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>
6. had scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>	39. tumor or abnormal growth	<input type="checkbox"/>	<input type="checkbox"/>
7. had high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	40. HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/>
8. had low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	41. venereal disease	<input type="checkbox"/>	<input type="checkbox"/>
9. had artificial prosthesis. joints or heart valve	<input type="checkbox"/>	<input type="checkbox"/>	42. hives skin rash, hay fever	<input type="checkbox"/>	<input type="checkbox"/>
10. had a stroke	<input type="checkbox"/>	<input type="checkbox"/>	43. viral infection and/or cold sores	<input type="checkbox"/>	<input type="checkbox"/>
11. anemia or other blood disorder	<input type="checkbox"/>	<input type="checkbox"/>	44. neurologic problems	<input type="checkbox"/>	<input type="checkbox"/>
12. emphysema	<input type="checkbox"/>	<input type="checkbox"/>	45. stomach or duodenal ulcer	<input type="checkbox"/>	<input type="checkbox"/>
13. tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	46. high cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
14. prolonged bleeding due to a slight cut	<input type="checkbox"/>	<input type="checkbox"/>	47. Are you, or have ever been or a smoker?	<input type="checkbox"/>	<input type="checkbox"/>
15. kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	48. Are you presently being treated for any other illness?	<input type="checkbox"/>	<input type="checkbox"/>
16. asthma	<input type="checkbox"/>	<input type="checkbox"/>	49. Has your general health changed recently?	<input type="checkbox"/>	<input type="checkbox"/>
17. breathing problems (sinus, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	50. Are you presently taking dietary supplements?	<input type="checkbox"/>	<input type="checkbox"/>
18. sleep disorder or problems (snoring, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	51. Are you often fatigued or feeling exhausted?	<input type="checkbox"/>	<input type="checkbox"/>
19. hormone deficiency	<input type="checkbox"/>	<input type="checkbox"/>	52. Are you female and taking prescription birth control?	<input type="checkbox"/>	<input type="checkbox"/>
20. lumps or swelling in the mouth	<input type="checkbox"/>	<input type="checkbox"/>	53. Are you female and currently pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
21. liver disease	<input type="checkbox"/>	<input type="checkbox"/>	54. Are you are taking medication for weight management?	<input type="checkbox"/>	<input type="checkbox"/>
22. jaundice	<input type="checkbox"/>	<input type="checkbox"/>	55. Are you considered to be very emotionally sensitive	<input type="checkbox"/>	<input type="checkbox"/>
23. thyroid or parathyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	56. Are you male with a prostrate disorder?	<input type="checkbox"/>	<input type="checkbox"/>

• Describe any current medical treatment, impending surgery or other treatment that might possibly affect your dental treatment.

• List all medications, supplements and/or vitamins taken within the last 2 years: (Ask for another sheet if you have more than 6)

Drug/Supplement	Purpose	Drug/Supplement	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

IT'S IMPORTANT THAT YOU ADVISE US OF ANY CHANGES IN YOUR MEDICAL STATUS OR MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

- Patient Name: _____
- How would you rate the condition of your mouth? Excellent Good Fair Poor
- Referred by: _____ • I routinely see my dentist every _____ months
- Previous Dentist: _____ • How long have you been a patient? _____ / _____ Mos./Yrs
- Date of most recent treatment other than a cleaning: _____ / _____ / _____ • Date of most recent X-rays _____ / _____ / _____
- Date of most recent dental exam: _____ / _____ / _____
- What is your immediate concern? _____

Please answer the following questions so that we may offer appropriate personalized solutions for your dental care:

1. Please let us know if you are fearful of dental care. On a scale of 1 (not fearful) to 10 (very fearful), how would you rate yourself? Circle one: 1 2 3 4 5 6 7 8 9 10

N

YES O

YES NO

- | | | | | | |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 2. Have you had an unfavorable dental experience? | <input type="checkbox"/> | <input type="checkbox"/> | 3. Have you had any teeth removed? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you self-conscious about your teeth? | <input type="checkbox"/> | <input type="checkbox"/> | 5. Have you ever whitened (bleached) your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you or have you ever worn a bite appliance? | <input type="checkbox"/> | <input type="checkbox"/> | 7. Do you have any problems chewing gum? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have tension headaches or sore teeth? | <input type="checkbox"/> | <input type="checkbox"/> | 9. Are your teeth crowding or developing spaces? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Are your teeth sensitive to hot, cold, biting or sweets? | <input type="checkbox"/> | <input type="checkbox"/> | 11. Have you had any cavities within the past 3 years? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you have a dry mouth? | <input type="checkbox"/> | <input type="checkbox"/> | 13. Do you avoid brushing any part of your mouth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Do you notice any holes or pitting in your teeth? | <input type="checkbox"/> | <input type="checkbox"/> | 15. Have you experienced receding gums? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Are your teeth becoming loose? | <input type="checkbox"/> | <input type="checkbox"/> | 17. Have you had complications from past dental care? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have you ever had trouble getting numb or reacting to local anesthetic? | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Did you ever have braces, orthodontic treatment or had your bite adjusted? | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Is there anything about the appearance of your teeth that you would like to change? | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Have you been disappointed with the appearance of previous dental work? | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Do you have any problem chewing bagels or other hard foods? | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. During the past 5 years, have your teeth become shorter, thinner, worn or developed other changes? | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Do you have pain, sounds, limited opening, locking or popping in your jaw joint? | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Do you have more than one bite or do you clench or squeeze your jaw to get your teeth to fit together? | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Do your teeth interrupt your sleep or do you wake up with a sensation in your teeth? | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth? | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Have you experienced a burning sensation in your mouth? | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Have you ever been diagnosed or been treated for periodontal (gum) disease? | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Have you noticed an unpleasant taste or odor in your mouth? | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Is there anyone with a history of periodontal disease in your family? | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Do your gums bleed when brushing, flossing or eating? | | | | <input type="checkbox"/> | <input type="checkbox"/> |

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Pearlman, Seidman & Newman

Confidential Information

Patient Last Name	First Name	MI	Sex		Home Phone	Cell Phone	
Street Address	Apt	City		ST	Zip	Email	Social Security #
Date of Birth	Mailing Address (if different than above)				Marital Status		<input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> Under Age 18

- Patient/Guardian's Employer: _____ Occupation: _____
- Work Address: _____ Work phone: _____ Ok to Call? Y / N
- Spouse's Name: _____ Cell Phone: _____
- Employer: _____ Occupation: _____
- Work Address: _____ Work phone: _____ Ok to Call? Y / N

Emergency Information: who do we contact in case of an emergency (other than your home)

Name	Relationship	Home Phone	Work Phone	Cell Phone

Other Family Members that are patients here: _____

Who can we thank for referring you to our office: _____

PLEASE COMPLETE THE FOLLOWING IF YOU HAVE INSURANCE COVERAGE

Insurance Company Name	Insurance Company Address	Phone	Group/Program#
Subscriber's Name	Subscriber's Birthdate	Patient's Relationship to Subscriber <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT	
Subscriber's SS#			

Insurance Subscriber's Employer (if different from above): _____

Employer's Address _____

Insurance Company Name	Insurance Company Address	Phone	Group/Program#
Subscriber's Name	Subscriber's Birthdate	Patient's Relationship to Subscriber <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT	
Subscriber's SS #			

Secondary Insurance Subscriber's Employer (if different from above): _____

Employer's Address _____

Assignment and Release

I hereby authorize my insurance benefits to be paid directly to the dentists. I am financially responsible for any balances due and authorize the dentists to release any information for this claim. I authorize my records can be used by the doctor if he so determines.

In consideration of the services rendered to me by this dental office I am obligated to pay said office in accordance with its credit terms and policy.

I consent to the making of video tapes, photographs and x-rays before, during, and after treatment, and to the use of same by doctor in scientific papers or demonstrations.

I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

Patient/Guardian Signature: _____ Date: _____