PATIENT HEALTH HISTORY

Date _____

Name_____ Spouse's name _____

Address_____ City _____ Zip _____

Telephone H. _____W. _____C. _____

Birthdate _____ M □ F □

E-mail address _____

Who introduced you to our office?_____

What brings you to our office today? _____

DENTAL HISTORY

Approx. date of last dental visit _____ Date of last dental cleaning_____
Approximate date of last full set of x-rays (18 films or panoramic)_____
Are you currently experiencing pain in your mouth?……...…...____yes____no
Do your gums bleed when brushing your teeth?…….….____yes____no
Do you presently have a sore in your mouth?…….….____yes____no
Do you have un-replaced missing teeth?…….....____yes____no
Were replacements ever suggested?…….....____yes____no
Is any part of your mouth sensitive to (circle): pressure, chewing, temperature, sweets?
If so, where?_____
Does food catch between your teeth? ____yes_____no If so, where?_____
Have you ever had local anesthetic (Novocaine, Xylocaine, etc.)?……..____yes____no
Have you ever had an unfavorable reaction to anesthetic?…….. ____yes____no

Have you ever had botox and/or dermal filler therapy? ____ If not, are you interested? _____
Are you satisfied with your teeth and their appearance? _____
What would you like to change about your smile, if anything?_____
_____
_____
_____

MEDICAL HISTORY

Medical Doctor's Name _____Phone #_____
Are you in good health?……......_____yes_____no
Are you under the care of a physician……......_____yes_____no
If yes, please explain: _____
Have you had a serious illness or operation?……......_____yes_____no
If yes, please explain; _____
Women: are you pregnant?……......_____yes_____no
Do you use: ……..Tobacco? □yes □no……..Controlled substances? □yes □no…….

Joint Replacement. Have you had total joint (hip, knee, elbow, finger) replacement? _____yes _____no
Heart Valve/Heart Murmur. Do you have either of these?…… _____yes _____no
Have you been told you need antibiotics prior to dental treatment?…… _____yes _____no

Are you allergic to any of the following?:
□ Aspirin □ Penicillin □ Codeine □ Sulfa drugs □ Latex □ Local anesthetics
□ Metal □ Acrylic □ Sedatives □ Barbiturates □Other If yes, please explain: _____
_____

My last physical examination was _____
Do you have, or have you had, any of the following?: (please circle)

AIDS/HIV	Cough, persistent	High blood pressure	Skin rash
Alzheimer's	Diabetes	Jaw pain	Stroke
Anemia	Epilepsy	Kidney disease	Swelling of feet/ankles
Arthritis	Fainting	Liver disease	Thyroid problems
Asthma	Glaucoma	Pacemaker	Tonsillitis
Back problems	Headaches	Respiratory disease	Tuberculosis
Bleeding abnormally	Heart problems	Rheumatic Fever	Ulcer
Cancer	Hepatitis A (infectious)	Scarlet Fever	
Chemotherapy	Hepatitis B (serum)	Shortness of breath	

Please list any medications you are currently taking: _____
_____
_____

Do you have any disease, condition or problem not listed above?……..._____yes_____no
If yes, please explain_____
Do you use more than two pillows to sleep?……......_____yes_____no
Have you lost or gained more than 10 pounds in the past year?…….._____yes_____no
Are you thirsty much of the time?……......_____yes_____no

_____
Patient or Guardian's signature

GORDON DENTAL CARE

Insurance Information Sheet

We will always work, to the best of our ability, to maximize the payments of your insurance company for you.

Name: _____

Policy Holder: _____ Relationship: _____

Policy Holder SSN: _____Policy Holder DOB: _____

Employer: _____

Insurance Company: _____ Group# _____

Insurance Phone #: _____

I authorize Gordon Dental Care to submit claims electronically to my insurance carrier and to receive the payment for claims for my treatment.

Signature _____ Date _____