

PATIENT INFORMATION & HEALTH HISTORY



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420 West Elm Ave.
Hanover, PA 17331
Phone 632-4164

Patient's Name: _____
Address: _____
Residence Phone: _____
Person responsible for this account: _____
Address of responsible party if different: _____
Whom may we thank for referring you to our office: _____

Date of Birth: _____
Employer: _____
Business Phone: _____
SS Number: _____

Primary Dental Insurance Plan: _____
Insurance Company: _____
Group #: _____
Date of birth of policy holder: _____

DENTAL HISTORY: Yes/No (please check one)

How do you feel about your teeth/smile? _____

Date of last dental exam: _____

Chief oral complaint: _____

Teeth sensitive to hot, cold, pressure/sweets	Yes ___ No ___	Smoke	How long?	Yes ___ No ___
Gums bleed easily	Yes ___ No ___	Have you ever had an adverse reaction		
Grinding or clenching	Yes ___ No ___	to dental treatment?		Yes ___ No ___
Pain around ears	Yes ___ No ___	Have dental implants?		Yes ___ No ___
Clicking sound in ear while chewing	Yes ___ No ___	Growth or sore spots in mouth?		Yes ___ No ___
Periodontal treatment (gums)	Yes ___ No ___	Have you ever had trauma to head or jaw?		Yes ___ No ___
Orthodontic treatment (braces)	Yes ___ No ___	History of cold sores?		Yes ___ No ___

MEDICAL HISTORY: Yes/No (please check one)

Physician: _____ Date of last physical: _____

Currently under Medical Treatment: Yes ___ No ___ List all medications: _____

Any drug allergies: (list) _____

Have you ever been exposed to A.I.D.S. virus? Yes ___ No ___

Has a physician advised you to pre-medicate prior to dental treatment? Yes ___ No ___

Have you ever had

Stroke	Yes ___ No ___	Excessive bleeding from cut	Yes ___ No ___	Tuberculosis/Lung disease	Yes ___ No ___
Asthma	Yes ___ No ___	Bruise easily	Yes ___ No ___	Hormone or Thyroid problems	Yes ___ No ___
High blood pressure	Yes ___ No ___	Arthritis	Yes ___ No ___	Pregnant	Yes ___ No ___
Diabetes	Yes ___ No ___	Allergy or Hay fever	Yes ___ No ___	History of fainting	Yes ___ No ___
Any heart ailments	Yes ___ No ___	Kidney problems	Yes ___ No ___		
Rheumatic fever	Yes ___ No ___	Hepatitis/Liver problems	Yes ___ No ___		
Heart murmur	Yes ___ No ___	Hip or joint replacement	Yes ___ No ___		
Blood diseases	Yes ___ No ___				

Do you have an allergy to latex? Yes ___ No ___ Do you have allergies to jewelry? Yes ___ No ___

Are you taking aspirin on a daily basis? Yes ___ No ___ Do you take birth control? Yes ___ No ___

Do you have anxiety attacks? Yes ___ No ___ Do you have any physical limitations? Yes ___ No ___

Do you take any herbal remedies (St. John's wort, ginseng, etc)? Yes ___ No ___

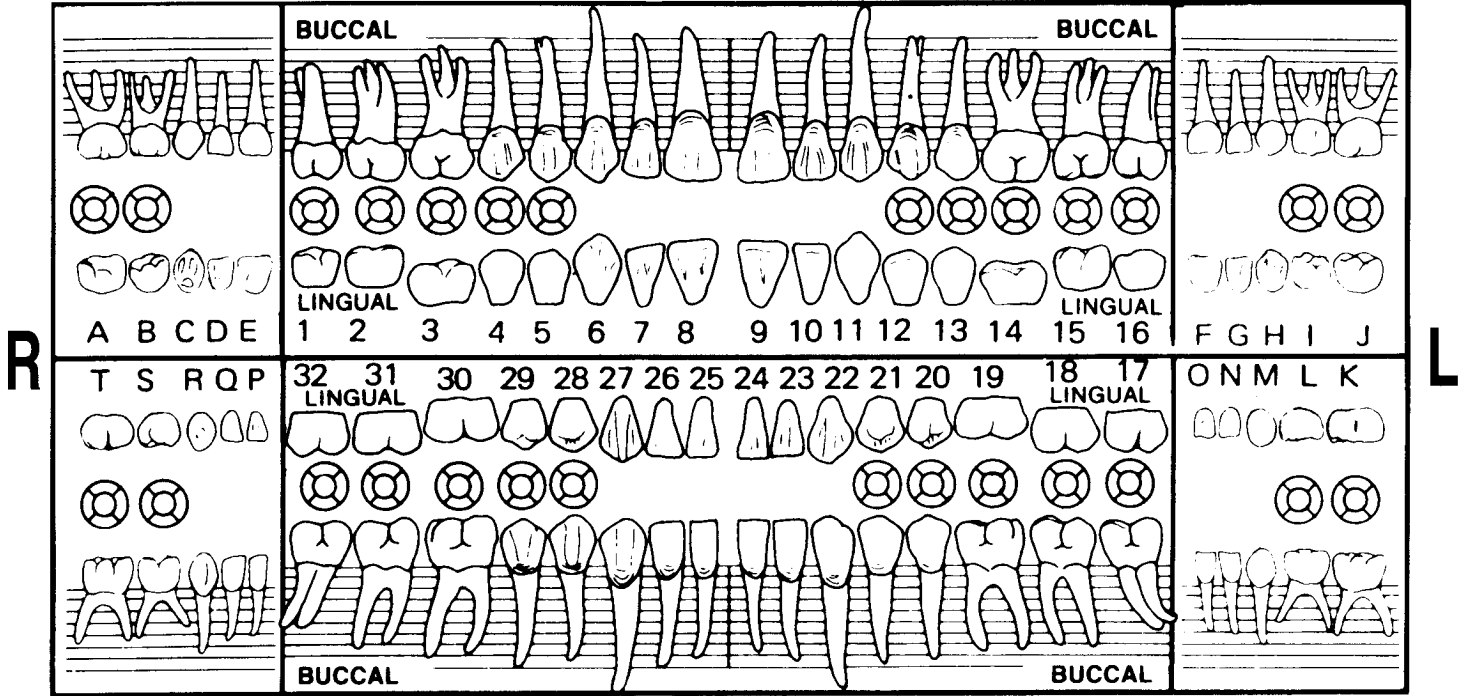
HEALTH HISTORY (Medication Update): _____

This is my consent for treatment by Dr. Fink and his associates. I understand and agree that (regardless of any Insurance status), I am responsible for the balance on my account for any dental services rendered. I also grant release of information for any insurance claims filed in my name, or my dependents.

Signature _____ Date _____

CLINICAL RECORD

PATIENT NAME		MEDICAL ALERT	
PATIENT ACCOUNT NO.		PHONE NUMBER	
		PRE-MEDICATION	



SOFT TISSUE EXAM

DATE	
PERIODONTUM	
LYMPHATICS	
TMJ	
BUCCAL MUCOSA	
FLOOR OF MOUTH	
TONGUE	
HARD PALATE	
SOFT PALATE	
OCCCLUSION	

INITIALS

COMMENTS: _____

INITIAL PERIODONTAL EXAM **DATE** _____

INFLAMMATION: SEVERE MODERATE LIGHT
 PLAQUE: GENERALIZED AREA _____
 BLEEDS ON PROBING

CALCULUS: HEAVY MODERATE LIGHT
 SUPRA SUB STAIN

ORAL HYGIENE: POOR FAIR GOOD

FLOSSING: YES NO

ATTACHED GINGIVA: PINK RED MAGENTA
 STIPPLED GLOSSY GRANULAR

CONSISTENCY: FIRM BOGGY FIBROUS

MARGINS: THIN SWOLLEN RECEDED IRREGULAR

PAPILLA: POINTED BLUNTED FLAT INVERTED
 PINK RED MAGENTA
 FIRM BOGGY FIBROUS

POCKETING: GENERALIZED AREA _____

DIAGNOSIS: MODERATE PERIODONTITIS
 ADVANCED PERIODONTITIS