Dental Health History Form

Patient Name: First_____MI___Last _____Nickname_____

What are your goals in coming to our practice today? _____

What is important to you in a dentist or dental practice? _____

Date of last radiographs (x-rays) and exam _____

Date of last dental cleaning _____

Previous Dentist _____**Phone** _____

If you left your previous dentist, what are the reasons? _____

Are you experiencing any pain now? ☐ Yes ☐ No

If yes, please describe _____

Have you ever been pre-medicated for dental treatment (taken antibiotics before dental treatment) ☐ Yes ☐ No

If yes, why? _____

Have you been anxious about having dental treatment? ☐ Yes ☐ No

If yes, would you be comfortable sharing why? _____

What concerns do you currently have with your oral health or smile? *(check all that apply)*

☐ Jaw joint pain	☐ Unhappy with appearance of teeth	☐ Tooth sensitivity to hot/cold or anything else
☐ Clenching or grinding of teeth	☐ Overbite	If yes, where? _____
☐ Discolored teeth	☐ Underbite	☐ Difficulty chewing
☐ Crowding/Crooked teeth	☐ Uncomfortable bite	If yes, where? _____
☐ Missing teeth	☐ Speech problems	☐ Bleeding gums
☐ Spaces in between teeth	☐ Bad breath	If yes, where? _____
☐ Loose tooth/teeth	☐ Snoring or sleep apnea	If yes, while brushing? ☐ Yes ☐ No
☐ Tooth shape or size	☐ Food gets caught in between teeth	☐ Other_____

Have you ever had orthodontic treatment? ☐ Yes ☐ No

If yes, when? _____

Have you ever had periodontal (gum tissue) treatment, such as deep cleaning, or periodontal surgery? ☐ Yes ☐ No

List treatments: _____

Have you whitened your teeth in the past? ☐ Yes ☐ No

If yes, what method? _____

Dr. M.K. Nijjar & Dr. Ruchi K. Sahota
Family Dentistry

Patient Information Form

Today's Date _____

Patient Name: First _____ M_____ Last _____Nickname_____

Address: Street _____ City _____State ____Zip _____

Phone: Home_____ Work _____Mobile_____

E-mail address _____

Social Security Number _____ **Date of Birth** _____

Sex ☐ Male ☐ Female **Marital Status** ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Whom may we thank for referring you?

☐ One of our valued patients *(name of Patient* _____

☐ Advertisement _____

☐ Our Web site ☐ Other _____

Please list other members of your immediate family who are patients in our practice.

_____ _____ _____ _____

In case of emergency, who should be notified? _____

Relationship to patient _____**Home** _____ **Mobile Phone** _____

Is the patient a Minor? ☐ Yes ☐ No **Full-time Student** ☐ Yes ☐ No **Name of School**_____

Mother's Work# _____ **Mobile#**_____

Father's Work#_____ **Mobile#**_____

Name of Responsible Party: First_____ Last _____

Date of Birth _____**Relationship to Patient** ☐ Self ☐ Spouse ☐ Parent ☐ Other_____

If patient is a Minor, Primary residency ☐ Both Parents ☐ Mom ☐ Dad ☐ Step Parent ☐ Shared Custody ☐ Guardian

Address: *(if different from patient)* Street _____City _____State _____Zip_____

Phone: Home_____ Work _____Mobile_____

Dental Benefit Plan Information

Primary Dental Plan Name_____**Group No.** _____

Name of Insured _____**Date of Birth** _____**Social Security Number** _____

Insured Person's Employer_____

ID Number _____**Patient Relationship to Insured (circle) spouse child other**

Secondary Dental Plan Name _____**Group No.** _____

Name of Insured _____**Date of Birth** _____**Social Security Number** _____

Insured Person's Employer_____

ID Number _____**Patient Relationship to Insured**_____

Confidential Health History Form

Patient Name: First _____MI ___ Last_____**Date of Birth** _____

I. Circle appropriate answer *(Leave blank if you do not understand the question)*

1. **Yes / No** **Is your general health good?**
   If NO, explain _____
2. **Yes / No** **Has there been a change in your health within the last year?**
   If YES, explain _____
3. **Yes / No** **Have you gone to the hospital or emergency room or had a serious illness in the last three years?**
   If YES, explain _____
4. **Yes / No** **Are you being treated by a physician now?**
   If YES, explain _____
   Date of last medical exam _____**Reason for exam** _____

II. Have you experienced any of the following? *(Please Circle Yes or No for each)*

Yes / No	Chest pain (angina)	Yes / No	Blood in stools	Yes / No	Frequent vomiting
Yes / No	Fainting spells	Yes / No	Diarrhea or constipation	Yes / No	Jaundice
Yes / No	Recent significant weight loss	Yes / No	Frequent urination	Yes / No	Dry mouth
Yes / No	Fever	Yes / No	Difficulty urinating	Yes / No	Excessive thirst
Yes / No	Night sweats	Yes / No	Ringing in the ears	Yes / No	Difficulty swallowing
Yes / No	Persistent cough	Yes / No	Headaches	Yes / No	Swollen ankles
Yes / No	Coughing up blood	Yes / No	Dizziness	Yes / No	Joint pain or stiffness
Yes / No	Bleeding problems	Yes / No	Blurred vision	Yes / No	Shortness of breath
Yes / No	Blood in urine	Yes / No	Bruise easily	Yes / No	Sinus problems

III. Have you had or do you have any of the following? *(Please Circle Yes or No for each)*

Yes / No	Heart disease	Yes / No	Hospitalization	Yes / No	Eating disorders
Yes / No	Family history of heart disease	Yes / No	Surgeries	Yes / No	Osteoporosis
Yes / No	Artificial joint	Yes / No	Diabetes	Yes / No	Thyroid disease
Yes / No	Stomach Problems or ulcers	Yes / No	Family history of diabetes	Yes / No	Hepatitis
Yes / No	Heart defects	Yes / No	Tumors or cancer	Yes / No	Sexual transmitted disease
Yes / No	Heart murmur	Yes / No	Chemotherapy	Yes / No	Herpes
Yes / No	Rheumatic fever	Yes / No	Radiation	Yes / No	Canker or cold sores
Yes / No	Skin disease	Yes / No	Arthritis, rheumatism	Yes / No	Anemia
Yes / No	Sleep apnea or snoring	Yes / No	Liver disease	Yes / No	Emphysema/lung disease/Asthma
Yes / No	High blood pressure	Yes / No	Kidney or bladder disease	Yes / No	Eye disease
Yes / No	Seizures	Yes / No	Stroke	Yes / No	Transplants
Yes / No	AIDS/HIV	Yes / No	Anxiety	Yes / No	Tuberculosis
Yes / No	Depression	Yes / No	Treatment for emotional condition.		

IV. Are you allergic to or have you had a reaction to any of the following? *(Please Circle Yes or No for each)*

Yes / No	Aspirin	Yes / No	Valium	Yes / No	Tetracycline
Yes / No	Darvon	Yes / No	Demerol	Yes / No	Vicodin
Yes / No	Codeine	Yes / No	Penicillin	Yes / No	Percodan
Yes / No	Latex	Yes / No	Food	Yes / No	Nitrous oxide
Yes / No	Local anesthetic (Novocaine, Xylocaine, Septocaine)	Yes / No	Erythromycin	Yes / No	Metal
		Yes / No	Clindamycin		

Other allergies: _____

V. Are you taking or have you ever taken any of the following *(Please Circle Yes or No for each)*

Yes / No	Recreational drugs	Yes / No	Tobacco in any form	Yes / No	Antibiotics
Yes / No	IV medications	Yes / No	Alcohol	Yes / No	Supplements
Yes / No	Weight loss medications	Yes / No	Bisphosphonate (Fosamax)	Yes / No	Aspirin
Yes / No	Cortico-Steroids	Yes / No	Heparin	Yes / No	Other blood thinners Coumadin, Plavix,etc.

Please list all medications you are currently taking _____

VI. Women only *(Please Circle Yes or No for each)*

Yes / No **Are you or could you be pregnant? If YES, what month? _____ OBGYN _____Ph: _____**
Yes / No **Are you nursing? If yes, name of pediatrician _____Ph: _____**
Yes / No **Are you taking birth control pills?**

VII. All patients *(Please Circle Yes or No for each)*

Yes / No **Do you have or have you had any other diseases or medical problems NOT listed on this form?**

If YES, explain _____

Yes / No **Have you ever been asked by your physician to take antibiotics before dental treatment?**

If YES, when & why_____Medication: _____

Yes / No **Have you ever taken Fen-Phen or Redux?**

If YES, when _____

Yes / No **Is there any issue or condition that you would like to discuss with the dentist in private?**

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature _____Date _____

Physician's Name _____Phone Number _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of the staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient (Parent or Guardian)	Date	Signature of Dentist	Date

Patient acknowledgement of receipt of Notice of Privacy Practices.

I, _____, acknowledge that I have received a copy of the notice of privacy practices.

Patient signature	Date	Relationship to patient (if applicable)

Patient acknowledgement of receipt of Dental Materials Fact Sheet.

I,_____, acknowledge that I have received a copy of the dental materials fact sheet dated May 2004 as required by law.

Patient signature	Date	Relationship to patient (if applicable)