Preventive Dental Services
Happy Healthy Smiles

549 Grubstake Ave, Suite A • Homer, AK 99603 • (907) 235 - 1286

Please answer all questions on **both** sides, so that we may diagnose your oral health as accurately as possible. All information will be kept strictly confidential. Thank You.

PATIENT'S NAME _____ Preferred Name _____

❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

❑ Male ❑ Female Social Security No._____ Birthdate _____

Mailing Address _____ Home Phone _____

City _____ State _____ Zip Code _____

Cell _____ Work _____ Email _____

Whom may we thank for referring you? ❑ Patient/family ❑ Location/sign ❑ Website ❑ Radio ❑ Employee
❑ Dr./Specialist ❑ Other: _____

Preferred method of communication: ❑ Text ❑ Email ❑ Cell ❑ Home ❑ Work

Name of Spouse _____ Birthdate _____ Social Security No. _____

Patient Occupation _____ Employer _____ Work Phone _____

Spouse Occupation _____ Employer _____ Work Phone _____

PRIMARY DENTAL INSURANCE	**SECONDARY DENTAL INSURANCE**
Insured _____	Insured _____
Relationship to Patient _____	Relationship to Patient _____
Employer _____	Employer _____
Insurance Co._____ Group # _____	Insurance Co._____ Group # _____
Insurance Co. Phone #_____ ID # _____	Insurance Co. Phone #_____ ID # _____
Insured Birthdate _____	Insured Birthdate _____
Employee's S.S. No._____	Employee's S.S. No._____

Person responsible for payment:_____

* * * * * *

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT?

Name _____ Home Ph. No._____ Work Ph. No._____

Relationship to Patient _____

DENTAL HISTORY

Chief dental concern: _____

_____

Are you nervous about having dental treatment?	Yes	No
Have you ever had a bad dental experience?	Yes	No
Do you have difficulty or pain when opening (yawning)?	Yes	No
Does your jaw get stuck, locked or "go out"?	Yes	No
Difficulty / pain when chewing, talking, or using your jaws? Teeth?	Yes	No
Do you have noises in your jaw joints?	Yes	No
Pain about the ears, temples or cheeks?	Yes	No
Does your bite feel uncomfortable or unusual?	Yes	No
Have you had a recent injury to your head / jaw?	Yes	No
Have you been treated for a jaw joint problem?	Yes	No
Do your teeth ever feel loose?	Yes	No
Does food catch in-between your teeth?	Yes	No
How often do you brush?_____ Floss? _____	Yes	No
Any difficulty chewing your food?	Yes	No
Have you ever had periodontal disease?	Yes	No
Are your teeth sensitive to cold / heat / etc?	Yes	No
Have you ever been premedicated for dental work?	Yes	No
Do you have frequent Headaches?	Yes	No
Are you happy with the way your smile looks?	Yes	No

If not, what would you change? _____

_____

_____

HEALTH HISTORY

Are you having any pain or discomfort at this time?	Yes	No
Do you smoke or use tobacco in any form?	Yes	No
Have you been hospitalized in the past 2 years?	Yes	No
Have you been under the care of a medical doctor during the past 2 years?	Yes	No

Physician Name: _____

Address _____ Phone:_____

Are you currently taking any medications / drugs?	Yes	No
Have you ever had a head injury?	Yes	No
Women: Are you pregnant?	Yes	No

If yes, please list: _____

List Medications: _____

_____

_____

Please list any serious medical condition(s) that you have/had:

_____

Please check "Yes or No" to the following conditions:

Y	N		Y	N		Y	N		Y	N	
		Angina Pectoris			Sickle Cell Disease			Emphysema / Asthma			Fever Blisters / Cold Sores
		Heart Disease / Attack / Stroke			Bruise Easily			Cough / Tuberculosis (TB)			Fainting / Dizzy Spells
		Heart Failure			Hemophilia			Arthritis / Rheumatism			Epilepsy / Seizures
		High / Low Blood Pressure			Liver Disease / Yellow Jaundice			Cortisone Medicine			Hay Fever / Sinus Trouble
		Congenital Heart Defect			Kidney Failure/Disfunction			Venereal Disease			Allergies / Hives
		Heart Murmur / Rheumatic Fever			Thyroid Disease			A.I.D.S. / H.I.V.			Shingles
		Heart Surgery			Ulcers			Hepatitis: A B C **(circle one)**			Nervousness
		Heart Pacemaker			Glaucoma			Frequent Headaches			Psychiatric Treatment
		Artificial Heart Valve			Chemotherapy / Cancer			Pain in Jaw Joint			Drug / Alcohol Addiction
		Diabetes			X-ray / Cobalt Treatment			Artificial Joints (Hip, Knee)			Blood thinner
		Blood Transfusion / Anemia			Cosmetic Surgery			Scarlet Fever			Splenectomy

Are you allergic to or have you reacted adversely to the following?

Antibiotics	Aspirin
Codeine	Latex
Metals / Jewelry	Local/Dental Anesthetic

Are you aware of being allergic to any other medications or substances? If yes, please list:

_____

_____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature _____ Date _____

Medical History Update

(For Office Use Only)

Date _____ Comments _____ Date _____ Comments _____

Date _____ Comments _____ Date _____ Comments _____

Date _____ Comments _____ Date _____ Comments _____

Date _____ Comments _____ Date _____ Comments _____

Date _____ Comments _____ Date _____ Comments _____