NEW PATIENT HEALTH HISTORY FORMS

WELCOME

Thank you for selecting our dental office!! We will strive to provide you with the best possible dental care. In order to help us meet all your dental healthcare needs, please fill out this form completely, in ink. If you have any questions or need assistance, please ask us, we are here to help you!

PERSONAL INFORMATION (please print)

Date:_____Birth date:_____

Patient's name:_____SSN:_____

Address:_____

City:_____State:_____Zip Code:_____

Home Phone:_____Work Phone:_____Cell Phone:_____

____Female ____Male Marital Status_____

Employer:_____Address:_____

Spouse:_____Employer:_____

Phone:_____Spouse's SSN, (if providing insurance)_____

Your Primary Physician:_____Phone:_____

Person responsible for this account:_____

In case of an emergency, who should be notified?_____

Phone:_____Pharmacy Phone:_____

Dental Insurance Company:_____Policy/Grp.#_____

Referred to us by:_____

Correct answers to the following questions will allow Dr. Brochstein and our staff to treat you on a more individual basis, providing the care appropriate for your particular needs. Circle YES or NO, whichever applies, in response to the following questions. Your answers are for our records only and will be considered confidential.

DENTAL HISTORY

1. Are you having any DISCOMFORT at this time? YES NO

Are your teeth SENSITIVE to HOT - COLD - SWEETS - PRESSURE (If yes, please circle)

2. Have you ever had any trouble associated with previous dental treatment? YES NO

If yes, please explain_____

_____

3. Does dental treatment make you nervous? YES NO

___SLIGHTLY ___MODERATELY ___EXTREMELY

4. Approximate date of last dental visit:_____

5. How often do you brush?_____Brush type:___Soft ___Medium ___Hard

Do you use DENTAL FLOSS regularly? YES NO

6. Do you have or have you ever had any of the following?:

BLEEDING, TENDER or SORE gums? YES NO

Unpleasant taste/bad breath? YES NO

Burning tongue/lips - frequent BLISTERS? YES NO

Awareness of GRINDING/CLENCHING teeth? YES NO

7. Do you have HEADACHES, EARACHES, or NECK PAINS? YES NO

8. Do you have *difficulty opening your mouth*, or hear *noises in your jaw joints*? YES NO

9. Does your jaw ever get *"stuck", "locked", or "go out"*? YES NO

10. Have you previously been diagnosed/treated for a *temperomandibular disorder*? YES NO

(TMJ) If yes, when, and by whom_____

11. Have you ever worn BRACES or RETAINERS on your teeth? YES NO

12. Have you ever had ARTHRITIS? YES NO

GENERAL HEALTH HISTORY

1. Have you been a patient in the hospital in the past two years? YES NO

2. Have you been under a physician's care during the past two years? YES NO

3. Have you taken any type of *medicines* or *drugs* in the past year? YES NO

If yes, ***please list***-(include daily vitamins, birth control pills, etc.) ***anything taken daily:***

_____

_____

4. Are you a *smoker*? If yes, how much do you smoke?_____ YES NO

5. Are you ALLERGIC to *penicillin, codeine*, or any other *drugs/medicines?* YES NO

If yes, please list:_____

_____

6. Have you/any family members been advised of problems during *anesthesia*? YES NO

7. Have you ever had any *excessive bleeding* requiring special treatment? YES NO

8. Have you ever had any other serious illness(es)? YES NO

9. If female, are you PREGNANT now, or trying to become pregnant? YES NO

10.Are you currently on an ASPIRIN THERAPY? YES NO

PLEASE MARK (X) ANY OF THE FOLLOWING WHICH YOU HAVE OR HAVE HAD

__HEART DISEASE	__ARTHRITIS	__ANEMIA
__HEART MURMUR	__STROKE	__ASTHMA
__M.V.P.	__EPILEPSY	__COUGH
__HIGH BLOOD PRESSURE	__AIDS/HIV+/ARC	__DIABETES
__RHEUMATIC FEVER	__SINUS PROBLEMS	__HEPATITIS A/B/C
__TUBERCULOSIS	__PSYCHIATRIC CARE	__JAUNDICE
__CANCER – TYPE_____	__GLAUCOMA	__EMPHYSEMA
TREATMENT_____	__KIDNEY DISEASE	__SKIN RASHES
_____	__PACEMAKER	__DRUG/ALCOHOL
__CODEINE ALLERGY	__HEAD INJURIES	__ADDICTION
__PREGNANCY-----DUE	__ULCERS	__HERPES/SHINGLES
_____	__LIVER DISEASE	__MOUTH BLISTERS
__FERTILITY TREATMENT(S)	__SULFA DRUG	__PENICILLIN ALLERGY
__ARTIFICIAL JOINT(S)	__ALLERGY	__OTHER ALLERGIES_____
		_____

CHIEF DENTAL COMPLAINT/CONCERN:_____
_____

Are you having any DISCOMFORT at this time?	YES	NO
Are you UNHAPPY with the APPEARANCE of your TEETH?	YES	NO
Do you have DISCOLORED teeth that bother you?	YES	NO

IF YOU COULD WAVE A MAGIC WAND AND CHANGE ONE THING ABOUT YOUR SMILE, WHAT WOULD IT BE?_____
_____

INFORMED CONSENT

I GIVE PERMISSION FOR MY DENTIST AND HIS/HER CLINICAL TEAM TO TAKE ANY NECESSARY X-RAYS, PHOTOS, OR STUDY MODELS TO ENABLE COMPLETE DIAGNOSIS AND TREATMENT.

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I UNDERSTAND THAT ANY INSURANCE I MAY HAVE IS AN AGREEMENT BETWEEN ME, MY INSURANCE COMPANY AND MY EMPLOYER. I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR MY BALANCE REGARDLESS OF INSURANCE.

SIGNED_____DATE_____

PLEASE LET US KNOW OF ANY NEW MEDICAL CONDITIONS YOU MAY HAVE, AND/OR ANY NEW MEDICINES/DRUGS YOU ARE TAKING.