Paul E. Harvey, D.M.D., P.A.

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Patient Health History

The following is requested to assist our office in administering to you the most appropriate dental treatment. Please answer the questions to the best of your ability. Use the additional space for answers requiring clarification or any additional information. Thank you for your cooperation.

Date: _____ Patient Computer Code # _____

Name-(last) _____ (first) _____ (middle) _____

Home Address: _____

Business Address: _____

Phone: (Home) _____ (Business) _____ Social Security Number: _____

Date of Birth: _____ Sex: _____ Height: _____ Weight: _____

Occupation: _____

Marital Status (circle) Single Married Widowed Divorced

Spouse's Name: _____

Type of Dental Insurance (if applicable): _____

_____

Who were you Referred to us By and why did you choose our office: _____

_____

Reason for your visit: _____

Emergency information of an individual we can contact: Telephone Number: _____

Name: _____ Street Address: _____

City: _____ State: _____ Zip Code: _____

Medical Health History

General Health (please check): Excellent_____ Good_____ Fair_____ Poor_____

Who is your Medical Physician:.....Telephone Number: _____

Name: _____ Street Address: _____

City: _____ State: _____ Zip Code: _____

Last complete physical? _____ If so, for what reason? _____

_____

Are you taking any medications now? Yes_____ No _____ For what purpose? _____

_____

List all Medications: _____

_____

Are you allergic to: Antibiotics:_____ Codeine:_____ Aspirin:_____ Local Anesthetics:_____

Are you allergic to any other Medications? _____

Have you ever been hospitalized? If so give name of hospital, reason and dates:

_____

_____

Is your blood pressure Normal _____ Low _____ High _____ Medications? _____

Have you ever had any hips, knees, joints, or heart valves replaced?	Yes _____	No _____
Have you had any radiological diagnostic x-rays in the last five years?	Yes _____	No _____
Have you had any blood transfusions?	Yes _____	No _____
Are you currently trying to modify your weight?	Yes _____	No _____
Do you take any medications to help in weight reduction?	Yes _____	No _____
Do you smoke cigarettes? How many packs per day? _____	Yes _____	No _____
Do you consume alcohol on a daily basis?	Yes _____	No _____
Have you experienced any recent weight change?	Yes _____	No _____
Women: Are you pregnant? How long? _____	Yes _____	No _____
Do you experience premenstrual syndrome?	Yes _____	No _____

Have you ever been informed that you had or may have had any of the following?

Chest Pains	Yes _____	No _____	Heart Disease	Yes _____	No _____
Rheumatic Fever	Yes _____	No _____	Heart Murmur	Yes _____	No _____
Congenital Heart Defects	Yes _____	No _____	Hypertension	Yes _____	No _____
Fainting Spells	Yes _____	No _____	Kidney Problems	Yes _____	No _____
Stroke	Yes _____	No _____	Thyroid problems	Yes _____	No _____
Hormonal Problems	Yes _____	No _____	Ulcers	Yes _____	No _____
Tuberculosis (lung disease)	Yes _____	No _____	Diabetes	Yes _____	No _____
Epilepsy or Seizures	Yes _____	No _____	Anemia	Yes _____	No _____
Cancer or Leukemia	Yes _____	No _____	Psychiatric Problems	Yes _____	No _____
Sickle Cell Disease	Yes _____	No _____	Glaucoma	Yes _____	No _____
Prosthetic Valves or Joints	Yes _____	No _____	Bruise Easily	Yes _____	No _____
Jaundice	Yes _____	No _____	Asthma or Hay Fever	Yes _____	No _____
Allergies or Hives	Yes _____	No _____	Sinus Trouble	Yes _____	No _____
Arthritis	Yes _____	No _____	Excessive Urination or Thirst	Yes _____	No _____
Persistent Cough	Yes _____	No _____	Prolonged Bleeding Problems	Yes _____	No _____
Genetic Abnormalities	Yes _____	No _____	Sexually Transmitted Diseases.	Yes _____	No _____
Skin Diseases	Yes _____	No _____	(Gonorrhea, Syphilis,Genital Herpes)		
AIDS	Yes _____	No _____	HIV Positive	Yes _____	No _____
Unexplained Fevers	Yes _____	No _____	Prolonged Sore Throat	Yes _____	No _____
Enlarged Lymph Nodes	Yes _____	No _____	Night Sweats	Yes _____	No _____
Persistent Diarrhea	Yes _____	No _____	Bluish-Reddish Lesions	Yes _____	No _____
Fatigue	Yes _____	No _____	Adverse Medical Reactions	Yes _____	No _____

Have you ever tested positive for Hepatitis?	Yes _____	No _____
Have you ever tested positive for AIDS or HIV infection?	Yes _____	No _____
Do you have a history of cold sores, fever blisters, or canker sores?	Yes _____	No _____
Are you being treated with Immunosuppressive drugs?	Yes _____	No _____
Have you ever used drugs for recreational purposes?	Yes _____	No _____

Dental Health

Who was your previous Dentist?_____

When was your last Dental Visit?_____

If you could change anything about you smile what would it be?_____

How often do you brush your teeth? _____ How often do you floss your teeth? _____

What texture tooth brush do you use?..... Soft _____ Medium _____ Hard _____

Do you routinely use a mouth rinse? How often? _____..... Yes _____ No _____

Do you experience dry mouth (Xerostomia)? ..... Yes _____ No _____

Do your gums feel tender or swollen?..... Yes _____ No _____

Do your gums bleed while brushing and / or flossing?..... Yes _____ No _____

Do you avoid brushing any part of your mouth because of pain or sensitivity?..... Yes _____ No _____

Do you feel twinges of pain when your teeth come in contact with hot, cold, sweet, or sour?.... Yes _____ No _____

Are any of your teeth sensitive to air or during chewing?..... Yes _____ No _____

Do you chew on only one side of your mouth?..... Yes _____ No _____

Does food catch between your teeth?..... Yes _____ No _____

Do you feel your teeth are affecting your health in any way?..... Yes _____ No _____

Have you ever had professional advice in Dental home care?..... Yes _____ No _____

Do you clench or grind your teeth while sleeping or during the day?..... Yes _____ No _____

Do your facial muscles ever feel tired?..... Yes _____ No _____

Do you wear full dentures? Upper _____ Lower _____ ..... Yes _____ No _____

Do you wear partial dentures? Upper _____ Lower _____ ..... Yes _____ No _____

Do you have retention problems with your full or partial dentures?..... Yes _____ No _____

Do you gag easily?..... Yes _____ No _____

Would you like to have any missing teeth replaced if possible?..... Yes _____ No _____

Would you be interested in having Dental Implants to replace missing teeth?..... Yes _____ No _____

Are you apprehensive (nervous) about your Dental treatment?..... Yes _____ No _____

Would you like to have Nitrous Oxide or be premedicated with a Sedative prior to Dental treatment? Yes _____ No _____

Have you ever had any serious problems associated with previous Dental treatment?..... Yes _____ No _____

If yes, Please explain and Please add anything you feel is important for us to know: _____

Consent:

The undersigned hereby authorizes this office to perform all the necessary diagnostic procedures deemed appropriate to make a thorough diagnosis of the patient's Dental or Oral-facial needs including x-rays, study models, photographs, medications, and the use of local anesthetic agents. It is understood that all insurance policies are contracts between the patient and the insurance company. Our office will assist you in filing the forms necessary to help you obtain your monetary benefits. The undersigned agrees to authorize and request the patient's insurance company to pay directly to the above named Doctor (Paul E. Harvey, D.M.D., P.A.) the amount due the patient in any pending claim for Dental treatment or services, provided to the patient, by this office. The undersigned agrees to be responsible for any and all fees incurred during treatment at this office. Any unpaid balance, 90 days past due, is the direct responsibility and obligation of the patient and will be subject to a %1.5 per month finance charge (% 18 per year), as well as any associated legal costs of collection.

PATIENT SIGNATURE (Parent of Child or Guardian) DATE

DENTIST SIGNATURE DATE

DATE	UPDATED MEDICAL HISTORY (LIST ANY CHANGES IN MEDICAL HISTORY SINCE LAST DENTAL APPOINTMENT) -DENTAL STAFF INITIAL ALL ENTRIES-