**Paul E. Harvey, Jr., D.M.D. Andrew M. Harvey, D.M.D. Susan A. Harvey, D.M.D**

# Patient Information

610 Islington Street

Portsmouth, N.H. 03801

(603) 436-7810

**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.**

|  |  |  |  |
| --- | --- | --- | --- |
| Name-(last) |  | (first) | (middle) |
| Home Address: |  |  |  |
| Phone: (Home) | (Mobile) |  | Social Security Number: |
| Date of Birth: | Gender: |  | Pronouns: Height: Weight: |
| Occupation: |  |  |  |
| Business Address: |  |  | : |
| Marital Status (circle) | Single | Married | Widowed Divorced |
| Spouse/Partner’s Name: |  |  |  |

Type of Dental Insurance (if applicable):

Reason for your visit:

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

# Emergency Contact

**Emergency information** of an individual we can contact: Telephone Number: Name: Relation:

Address:

# 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

**I attest that the information given in this packet in its entirety is true and complete and will be updated if changes occur.**

# Health Provider Information:

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?

Are you taking any medications now? Yes No

List all Medications and the conditions that they are treating in the chart below. If more space is needed ask staff.

|  |  |  |  |
| --- | --- | --- | --- |
| MEDICATION | DOSAGE | FREQUENCY | CONDITION |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Have you ever been hospitalized or had major surgeries? If so, list the reasons and dates:

# Allergies:

Are you allergic to: Antibiotics: Codeine: Aspirin: Local Anesthetics: Latex: What are your reactions: Do you have any other allergies?

# Medical History:

Is your blood pressureNormal Low High Medications?

Have you ever been pre-med before a dental appointment? Yes No 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 ever taken Fosamax, Boniva, Actonel or any other

medications containing bisphosphonates? Yes No If yes, date

Have you lost/gained 10 lbs. within the past 6 months without trying? Yes No Do you use tobacco? If yes, what type and how often? Yes No Are you interested in quitting? Yes No Have you ever used drugs for recreational purposes? Yes No Do you consume alcohol on a daily basis? Yes No

Do you feel dependent on alcohol? Yes No

Have you experienced any recent weight change? Yes No

Are you pregnant? Yes No

Are you nursing/lactating? Yes No

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

How long?

|  |  |  |  |
| --- | --- | --- | --- |
| 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 / Canker Sores | 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 Jaundice Yes No

Allergies or Hives Yes No

Arthritis Yes No

Persistent Cough Yes No Genetic Abnormalities Yes No Skin Diseases Yes No

Bruise Easily Yes No

Asthma or Hay Fever Yes No

Sinus Trouble Yes No Excessive Urination or Thirst Yes No Prolonged Bleeding Problems Yes No Sexually Transmitted 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 | Blood Transfusions | Yes No |
| Osteoporosis | Yes No | Bluish-Reddish Lesions | Yes No |
| Fatigue | Yes No | Adverse Medical Reactions | Yes No |
| Immunosuppression | Yes No | Autism | Yes No |
| Hepatitis | Yes No | Cold Sores / Canker Sores | Yes No |
| Addiction (Drug or Alcohol) | Yes No | Gender Transition | Yes No |

If you answered “yes” to any item, please explain

# Dental Health:

Who was your previous Dentist? When was your last Dental Visit? If you could change anything about your 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

Do you gag easily? Yes

Would you like to have any missing teeth replaced if possible? Yes Would you be interested in having Dental Implants to replace missing teeth? Yes Are you nervous or anxious about receiving dental treatment? Yes

No No No No 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:

# DATE UPDATED MEDICAL HISTORY

(LIST ANY CHANGES IN MEDICAL HISTORY SINCE LAST DENTAL APPOINTMENT)

– DENTAL STAFF INITIAL ALL ENTRIES –