HARVEY FAMILY DENTISTRY EST. 1957

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# Patient Information

**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 |
|---|---|---|---|
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| | | | |
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| | | | |
| | | | |
| | | | |

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 pressure Normal _____ 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 _____ How long? _____

Are you nursing/lactating? 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 / 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 _____ | 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 _____ | 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 _____ 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 nervous or anxious about receiving 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: _____

_____

_____

| DATE | UPDATED MEDICAL HISTORY<br>(LIST ANY CHANGES IN MEDICAL HISTORY SINCE LAST DENTAL APPOINTMENT)<br>– DENTAL STAFF INITIAL ALL ENTRIES – |
| --- | --- |
| | |