andrea Yaley DDS

# Patient Information

Date _____ Patient's Name _____
Last First Middle

Address _____
Street Apt. # City State Zip

Home Ph. # (_____) _____ Work Ph. # (_____) _____ Cell Ph. # (_____) _____ Marital Status _____

Social Security # _____-_____-_____ Driver's Lic. # _____ E-Mail _____

Birthdate _____/_____/_____ Sex M F If patient is a minor, parent's/guardian's name _____

Name of nearest relative _____ Relationship _____

If patient is a full-time student, school name _____

School Address _____ Ph. # (_____)_____

Emergency Contact _____ Ph. # (_____) _____

# Responsible Party Information

Name_____
Last First Middle

Social Security # _____-_____-_____ Birthdate _____/_____/_____ Relationship to Patient _____

Residence _____
Street Apt. # City State Zip

How long at this address _____Home Ph.# (_____) _____Work Ph.# (_____) _____Fax # (_____) _____

Previous Address (if less than 3 years) _____

Employer _____Occupation _____ No. Years Employed_____

Employer Address_____

Spouse's Name _____

Social Security # _____-_____-_____ Birthdate _____/_____/_____ Work Ph. # (_____) _____ Fax # (_____)_____

# Insurance Information

Insured's Name _____ Insured's SS# _____ Insured's DOB _____ ID #_____

Insurance Company _____ Group # _____

Insurance Co. Address _____ Ph. # (_____) _____

Insured's Employer _____ Ph. # (_____) _____

Do you have dual coverage? Yes _____ No _____ If yes: **please complete the following secondary insurance information.**

Insured's Name _____ Insured's SS# _____ Insured's DOB _____ ID #_____

Insurance Company _____ Group # _____

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# Dental History Form

Patient Name _____ Date of Birth _____

Date of Last Dental Visit _____/_____/_____ Reason For Visit_____

Former Dentist _____ Phone Number _____

Address _____ City _____State _____ Zip _____

If you left your previous dentist, what was the reason? _____

What are your goals in coming to our practice today? _____

What is important to you in a dentist or dental practice?_____

## At Home Oral Hygiene Care

How often do you brush your teeth? _____

How often do you floss? _____

Do you use mouthwash? YES/NO

If YES, which kind? _____

Do you use any other dental home care products? YES/NO

If YES, which kind? _____

## **Circle the Appropriate Answer** (Leave blank if you do not understand the question)

1. Are you currently experiencing dental pain or discomfort? YES/NO
   If YES, explain: _____
2. Do your gums bleed? YES/NO
   If YES, explain: _____
3. Are your teeth loose? YES/NO
   If YES, explain: _____
4. Do you wear dentures or partials? YES/NO
   If YES, explain: _____
5. Have you ever been told you have gum disease? YES/NO
   If YES, explain: _____

6. Are your teeth sensitive to hot, cold, sweets or pressure? YES/NO
   If YES, explain: _____

7. Have you ever had any clicking, popping or discomfort in your jaw? YES/NO
   If YES, explain: _____

8. Do you brux or grind your teeth? YES/NO
   If YES, explain: _____

9. Do you wear an occlusal guard? YES/NO

10. Have you ever had orthodontic treatment (braces)? YES/NO
    If YES, explain: _____

11. Do you have dry mouth? YES/NO
    If YES, explain: _____

12. Does food or floss catch between your teeth? YES/NO
    If YES, explain: _____

13. Have you had any problems or an upsetting dental care experience associated with previous dental care? YES/NO
    If YES, explain: _____

14. Do you have fear or anxiety associated with dental treatment? YES/NO
    If YES, explain: _____

15. Have you ever been pre-medicated for dental treatment? YES/NO
    If YES, explain: _____

16. Have you ever had a reaction to anesthetic used with your dental treatment? YES/NO
    If YES, explain: _____

17. Are you happy with your smile? YES/NO
    If NO, explain:_____

18. What would you change about the present condition of your mouth?_____

    _____

19. Is there anything else you would like us to know about your dental history? YES/NO
    If YES, explain: _____

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful dental history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction.

_____ _____

Signature of Patient (Parent or Guardian) Date

_____ _____

Signature of Dentist Date

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# Confidential Health History

Patient Name:_____ Date of Birth: _____

## I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes / No Is your general health good?
   If NO, explain: _____
2. Yes / No Has there been a change in your health within the last year?
   If YES, explain: _____
3. Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain: _____
4. Yes / No Are you being treated by a physician now? If YES, explain: _____
   Date of last medical exam?_____ Reason for exam: _____
5. Yes / No Have you had problems with prior dental treatment?
   If YES, explain: _____
   Date of last dental exam:_____ Name of last treating dentist: _____
6. Yes / No Are you in pain now?
   If YES, explain: _____

## II. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING? (Please circle Yes or No for each)

| | | |
|---|---|---|
| Yes / No Chest pain (angina) | Yes / No Blood in stools | Yes / No Frequent vomiting |
| Yes / No Fainting spells | Yes / No Diarrhea or constipation | Yes / No Jaundice |
| Yes / No Recent significant weight loss | Yes / No Frequent urination | Yes / No Dry mouth |
| Yes / No Fever | Yes / No Difficulty urinating | Yes / No Excessive thirst |
| Yes / No Night sweats | Yes / No Ringing in ears | Yes / No Difficulty swallowing |
| Yes / No Persistent cough | Yes / No Headaches | Yes / No Swollen ankles |
| Yes / No Coughing up blood | Yes / No Dizziness | Yes / No Joint pain or stiffness |
| Yes / No Bleeding problems | Yes / No Blurred vision | Yes / No Shortness of breath |
| Yes / No Blood in urine | Yes / No Bruise easily | Yes / No Sinus problems |

Other: _____

## HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please circle Yes or No for each)

| | | |
|---|---|---|
| Yes / No Heart disease | Yes / No AIDS/HIV | Yes / No Psychiatric care |
| Yes / No Family history of heart disease | Yes / No Surgeries | Yes / No Osteoporosis |
| Yes / No Heart attack | Yes / No Hospitalization | Yes / No Thyroid disease |
| Yes / No Artificial joint | Yes / No Diabetes | Yes / No Asthma |
| Yes / No Stomach problems or ulcers | Yes / No Family history of diabetes | Yes / No Hepatitis |
| Yes / No Heart defects | Yes / No Tumors or cancer | Yes / No STDs |
| Yes / No Heart murmurs | Yes / No Chemotherapy | Yes / No Herpes |
| Yes / No Rheumatic fever | Yes / No Radiation | Yes / No Canker or cold sores |
| Yes / No Skin disease | Yes / No Arthritis, rheumatism | Yes / No Anemia |
| Yes / No Hardening of the arteries | Yes / No Emphysema or lung disease | Yes / No Liver disease |
| Yes / No High blood pressure | Yes / No Kidney or bladder disease | Yes / No Eye disease |
| Yes / No Seizures | Yes / No Stroke | Yes / No Transplants |
| Yes / No Cosmetic surgery | Yes / No Eating disorders | Yes / No Tuberculosis |

Other: _____

**IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING?**
(Please circle Yes or No for each)

| | | |
|---|---|---|
| Yes / No Aspirin | Yes / No Valium or other sedatives | Yes / No Codeine or other narcotics |
| Yes / No Penicillin or other antibiotics | Yes / No Latex | Yes / No Food |
| Yes / No Nitrous oxide | Yes / No Local anesthetic | Yes / No Metal |

Others: _____

**V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS?**
(Please circle Yes or No for each)

| | | |
|---|---|---|
| Yes / No Recreational drugs | Yes / No Tobacco in any form | Yes / No Antibiotics |
| Yes / No Over-the-counter medicines | Yes / No Alcohol | Yes / No Supplements |
| Yes / No Weight loss medications | Yes / No Bisphosphonate (Fosamax) | Yes / No Aspirin |
| Yes / No Anti-Depressants | Yes / No Herbal Supplements | |

Please list all prescription medications: _____

VI. **WOMEN ONLY** (Please circle Yes or No for each)

Yes / No Are you or could you be pregnant? If YES, what month? _____

Yes / No Are you nursing?

Yes / No Are you taking birth control pills?

VII. **ALL PATIENTS** (Please circle Yes or No for each)

Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?

If YES, please explain: _____

_____

Yes / No Have you ever been pre-medicated for dental treatment? If YES, why: _____

Yes / No Have you ever taken Fen-Phen? If YES, when: _____

Yes / No **Is there any issue or condition that you would like to discuss with the dentist in private?**

*The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically compromised situation, medical consultation may be needed prior to commencement of dental treatment.*

*I authorize the dentist to contact my physician.*

Patient's Signature: _____ Date: _____

Physician's Name: _____ Phone Number: _____

**Whom would you like us to contact in case of an emergency?**

**Name**: _____ **Relationship**: _____ **Phone Number**: _____

**I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.**

_____ _____ _____ _____

Signature of Patient (Parent or Guardian) Date Signature of Dentist Date

**MEDICAL UPDATES**

I have reviewed my Health History and confirm that it accurately states past and present conditions.

| DATE | PATIENT SIGNATURE | CHANGES TO HEALTH HISTORY | DENTIST INITIALS |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
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