

# PATIENT HEALTH RECORD FOR TEENS

Name \_\_\_\_\_ Age \_\_\_\_\_ Today's Date \_\_\_\_\_  
Name you prefer to be called \_\_\_\_\_ Birthdate \_\_\_\_\_  
Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_ License # \_\_\_\_\_  
Your Address: \_\_\_\_\_  
School Attending: \_\_\_\_\_

Parents' Names \_\_\_\_\_  
Address & Phone: \_\_\_\_\_  
Father Employed by: \_\_\_\_\_ Work # \_\_\_\_\_  
Mother Employed by: \_\_\_\_\_ Work # \_\_\_\_\_

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Dental Insurance:  Yes  No Name of Insured: \_\_\_\_\_  
Employer \_\_\_\_\_ Insured's Birthdate \_\_\_\_\_  
Insurance Co: \_\_\_\_\_ ID # \_\_\_\_\_ Group # \_\_\_\_\_  
Ins Co Address: \_\_\_\_\_ Phone # \_\_\_\_\_

Secondary Ins:  Yes  No Name of Insured: \_\_\_\_\_  
Employer \_\_\_\_\_ Insured's Birthdate \_\_\_\_\_  
Insurance Co: \_\_\_\_\_ ID # \_\_\_\_\_ Group # \_\_\_\_\_  
Ins Co Address: \_\_\_\_\_ Phone# \_\_\_\_\_

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Person to be billed: \_\_\_\_\_ Phone# \_\_\_\_\_  
Address if different from yours: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# MEDICAL HISTORY

PATIENT NAME \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions:

If yes, please list:

- Are you under a physician's care now?  Yes  No \_\_\_\_\_
- Have you ever been hospitalized or had a major operation?  Yes  No \_\_\_\_\_
- Any Stents, Pins, Plates placed in the last 6 months?  Yes  No \_\_\_\_\_
- Have you ever had a serious head or neck injury?  Yes  No \_\_\_\_\_
- Do you use herbal supplements?  Yes  No \_\_\_\_\_
- Do you use tobacco?  Yes  No \_\_\_\_\_
- Women: Are you pregnant or trying to get pregnant?  Yes  No \_\_\_\_\_
- Taking oral contraceptives/birth control?  Yes  No \_\_\_\_\_
- Are you on a special diet?  Yes  No \_\_\_\_\_

Nursing?  Yes  No

Are you taking any medications, pills, or drugs?  Yes  No Please list below:

Current Meds	Dose	Reason Taking
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you allergic to any of the following?

- Penicillin  Amoxicillin  Aspirin  Codeine  Sulfa  Sulfite  Iodine
- Milk protein  Minocycline  Cephalixin  Hydrocodone  Local Anesthetics
- Acrylic  Latex  Metal  Other: \_\_\_\_\_

Do you have, or have you had, any of the following:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Acid reflux                      | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Liver Disease              |
| <input type="checkbox"/> AIDS/HIV Positive                | <input type="checkbox"/> Drug Addiction            | <input type="checkbox"/> Low Blood Pressure         |
| <input type="checkbox"/> Allergies                        | <input type="checkbox"/> Dry Mouth                 | <input type="checkbox"/> Lupus                      |
| <input type="checkbox"/> Anaphylaxis/Allergic reaction    | <input type="checkbox"/> Emphysema                 | <input type="checkbox"/> Lung Disease               |
| <input type="checkbox"/> Anemia                           | <input type="checkbox"/> Epilepsy or Seizures      | <input type="checkbox"/> Mitral Valve Prolapse      |
| <input type="checkbox"/> Angina                           | <input type="checkbox"/> Excessive Bleeding        | <input type="checkbox"/> Pacemaker/Defibrillator    |
| <input type="checkbox"/> Arthritis/Gout                   | <input type="checkbox"/> Excessive Thirst          | <input type="checkbox"/> Parathyroid Disease        |
| <input type="checkbox"/> Artificial Heart Valve           | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Psychiatric Care           |
| <input type="checkbox"/> Artificial Joints/Knee, Hip, etc | <input type="checkbox"/> Frequent Cough            | <input type="checkbox"/> Radiation Treatments       |
| <input type="checkbox"/> Aspirin                          | <input type="checkbox"/> Glaucoma                  | <input type="checkbox"/> Renal Dialysis             |
| <input type="checkbox"/> Asthma                           | <input type="checkbox"/> Hay Fever                 | <input type="checkbox"/> Respiratory Problems       |
| <input type="checkbox"/> Blood Disease                    | <input type="checkbox"/> Hearing Problems          | <input type="checkbox"/> Rheumatic Fever            |
| <input type="checkbox"/> Blood Thinners                   | <input type="checkbox"/> Heart Attack/Failure      | <input type="checkbox"/> Rheumatism                 |
| <input type="checkbox"/> Cancer                           | <input type="checkbox"/> Heart Disease             | <input type="checkbox"/> Sinus Trouble              |
| <input type="checkbox"/> Chemotherapy                     | <input type="checkbox"/> Heart Murmur              | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Chest Pains                      | <input type="checkbox"/> Hemophilia                | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Clotting Disorder                | <input type="checkbox"/> Hepatitis                 | <input type="checkbox"/> Swelling of Limbs          |
| <input type="checkbox"/> Cold Sores/Fever Blisters        | <input type="checkbox"/> High Blood Pressure       | <input type="checkbox"/> Thyroid Disease            |
| <input type="checkbox"/> Congenital Heart Disorder        | <input type="checkbox"/> Immune Disease            | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Convulsions                      | <input type="checkbox"/> Irregular Heart Beat      | <input type="checkbox"/> Tumors or Growths          |
| <input type="checkbox"/> Coumadin                         | <input type="checkbox"/> Kidney Disease            | <input type="checkbox"/> Ulcers                     |

Have you ever had any serious illness not previously listed:  Yes  No Please list below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physicians Name/Phone # \_\_\_\_\_

### DENTAL HISTORY

Previous dentist's name/Phone # \_\_\_\_\_

Approximate length of time since you last had your teeth cleaned & examined \_\_\_\_\_

Date of last full mouth X-Rays \_\_\_\_\_

Reason for your visit to our office \_\_\_\_\_

\_\_\_\_\_

- Have you ever had complications following dental treatment? .....  Yes  No
- Are you apprehensive about dental treatment? .....  Yes  No
- Do your gums bleed or feel tender or irritated? .....  Yes  No
- Have you ever been diagnosed with periodontal disease? .....  Yes  No
- Have you had scaling & root planing - "deep cleaning"? .....  Yes  No
- Do you feel that you can't open your mouth as wide as you would like? .....  Yes  No
- Does your mouth go to one side when you open? .....  Yes  No
- Do you clench or grind your teeth? .....  Yes  No
- Do you have any teeth that hurt when you chew? .....  Yes  No
- Do you feel your teeth are wearing excessively? .....  Yes  No
- Do you have pain in the jaw joints? .....  Yes  No
- Do you have clicking or popping in the jaw joints? .....  Yes  No
- Do you have headaches, neck aches, shoulder aches? .....  Yes  No
- Have you worn braces on your teeth? .....  Yes  No
- Do you floss regularly? .....  Yes  No
- Does food wedge between your teeth? .....  Yes  No
- Do you have any spaces between your teeth? .....  Yes  No
- Do you dislike the length of your teeth or unhappy with their appearance? ....  Yes  No
- Are you missing any teeth? .....  Yes  No
- If yes, would you like to have the missing teeth replaced? .....  Yes  No
- Would you like your smile to look better or different? .....  Yes  No

Please add anything you feel is important about your dental or medical condition:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

\_\_\_\_\_  
Signature Date