



HOLDEN DENTAL CARE

PATIENT INFORMATION

Name: _____ MI _____ Today's Date: _____
Preferred Name: _____ Gender: M F Date of Birth: _____ Age: _____
Address: _____
City: _____ State: _____ Zip: _____
E-Mail: _____ I would like e-mail appointment reminders Yes__ No__
Home (____) _____ Cell(____) _____ Spouse: (____) _____
Married Widowed Separated Divorced Partnered Single Minor Spouse's Name: _____
Occupation: _____ Patient Employer / School: _____
Employer/Address: _____ Work (____) _____
IN CASE OF EMERGENCY, PLEASE CONTACT
Name: _____ Relation: _____ Phone(____) _____

RESPONSIBLE PARTY INFORMATION

Name: _____ Preferred Name: _____
Gender: M F Date of Birth: _____
Address: _____
City: _____ State: _____ Zip: _____
Home (____) _____ Cell(____) _____ Spouse: (____) _____
Employer / School: _____ Work (____) _____
Employer/Address: _____

DENTAL HISTORY

Please circle "yes" or "no" to indicate if you have had any of the following:
How often do you brush? _____ How often do you floss? _____
Bad Breath Yes No Jaw pain or tiredness Yes No Sores or growths in mouth Yes No
Bleeding Gums Yes No Lip or cheek biting Yes No Last dental visit
Blisters on lips or mouth Yes No Loose teeth or broken fillings Yes No
Burning sensation on tongue Yes No Mouth breathing Yes No Previous dentist
Chew on one side of the mouth Yes No Pain around ear Yes No
Clicking or popping jaw Yes No Permanent numbness in mouth Yes No
Dry Mouth Yes No or on face Yes No Orthodontic Treatment Yes No
Fingernail biting Yes No Sensitivity to cold Yes No Date _____
Food collections between teeth Yes No Sensitivity to heat Yes No
Grinding teeth Yes No Sensitivity to sweets Yes No Periodontal Treatment Yes No
Gums swollen or tender Yes No Sensitivity when biting Yes No Date _____

MEDICAL HISTORY

Have you been under the care of a medical doctor for anything other than yearly physicals during the past 2 years? **Yes No**

If yes, for what? _____

Physician's Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Have you been a patient in the hospital during the past 5 years? **Yes No** If yes, for what?

Please circle "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	Yes No	Diabetes/low blood sugar	Yes No	Radiation Treatment	Yes No
Anemia	Yes No	Emphysema/COPD	Yes No	Respiratory Disease	Yes No
Anxiety, Nervousness	Yes No	Epilepsy/Siezuers	Yes No	Rheumatic Fever	Yes No
Arthritis, Rheumatism	Yes No	Fainting or Dizziness	Yes No	Scarlet Fever	Yes No
Artificial Heart Valves	Yes No	Glaucoma	Yes No	Shortness of Breath	Yes No
Artificial Joints (Hip, knee, etc)	Yes No	Headaches	Yes No	Sinus Trouble	Yes No
Asthma	Yes No	Hearing Aid	Yes No	Skin Rash around or in Mouth	Yes No
Back/Neck Problems	Yes No	Heart Attack/surgery/disease	Yes No	Special Diet	Yes No
Bleeding Abnormally, with Surgery or Extractions	Yes No	Hepatitis Type _____	Yes No	Stroke	Yes No
Blood Disease	Yes No	Herpes	Yes No	Swollen Feet or Ankles	Yes No
Bruise Easily	Yes No	High Blood Pressure	Yes No	Tobacco Use	Yes No
Cancer	Yes No	Jaundice	Yes No	Chew / Smoke _____ Per Day	
Chemical Dependency	Yes No	Kidney Disease	Yes No	Thyroid Problems	Yes No
Chemotherapy	Yes No	Liver Disease	Yes No	Tonsillitis	Yes No
Circulatory Problems	Yes No	Low Blood Pressure	Yes No	Tuberculosis	Yes No
Congenital Heart Lesions	Yes No	Miral Valve Prolapse	Yes No	Tumor or growth on Head or Neck	Yes No
Contact Lens	Yes No	MRSA	Yes No	Ulcers or Gerd	Yes No
Cortisone Treatments	Yes No	Neurological Disorders	Yes No	Venereal Disease	Yes No
Cough, persistant or bloody	Yes No	Pacemaker	Yes No	Weight Loss, unexplained	Yes No
		Psychiatric Care	Yes No		

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Lonimin, Adipex, Fastin (brand names of phentermine). Pondimin (fenfluramine) and Redux (dexfenfluramine).

Yes No If yes, which? _____ When? _____

Have you ever taken any bisphosphonates such as Boniva, Fosamax, Actonel, Zometa, Aredria, or Bonefos?

Yes No If yes, which? _____ When? _____

Do you have any of the following? (Circle) Brain Implant Cochlear Implant Contact Lenses Defibrilator Hearing Aids Pacemaker.

WOMEN: Are you: **Pregnant?** Yes, _____ Months **No.** **Nursing?** Yes **No** **Taking birth control pills?** Yes **No**

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

Rx _____ For _____

Rx _____ For _____

If more, please attach a list.

ALLERGIES

Are you aware of having any allergies or adverse reactions to any of the following medications or substances? **Please circle if yes.**

Aspirin Barbiturates (Sleeping Pills) Codeine Hay

Fever/Seasonal Iodine Latex Local Anesthetic

Penicillin/Amoxicillin Sulfa

Other _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

Signature: _____ Date: _____

Patient, Parent, or Guardian

History Review:

Reviewed By: _____ Date _____