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			
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 5years? **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/Siezures	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
Artifical 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,		Hepatitis Type _________	Yes No	Stroke	Yes No
with Surgery or Extractions	Yes No	Herpes	Yes No	Swollen Feet or Ankles	Yes No
Blood Disease	Yes No	High Blood Pressure	Yes No	Tobacco Use	Yes No
Bruise Easily	Yes No	Jaundice	Yes No	Chew / Smoke ________ Per Day	
Cancer	Yes No	Kidney Disease	Yes No	Thyroid Problems	Yes No
Chemical Dependancy	Yes No	Liver Disease	Yes No	Tonsillitis	Yes No
Chemotherapy	Yes No	Low Blood Pressure	Yes No	Tuberculosis	Yes No
Circulatory Problems	Yes No	Miral Valve Prolapse	Yes No	Tumor or growth	
Congenital Heart Lesions	Yes No	MRSA	Yes No	on Head or Neck	Yes No
Contact Lens	Yes No	Neurological Disorders	Yes No	Ulcers or Gerd	Yes No
Cortisone Treatments	Yes No	Pacemaker	Yes No	Venereal Disease	Yes No
Cough, persistant or bloody	Yes No	Psychiatric Care	Yes No	Weight Loss, unexplained	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__________________