PRAIRIE'S EDGE
DENTAL

Patient Information & Health History

Patient: _____

Date: _____

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Dental & Medical Health History

Note: Your answers are for our records only and all information is confidential.

Date of Last Dental Visit: _____

How often do you brush your teeth? _____

What other dental aids do you use?

☐ Brush ☐ Dental Floss ☐ Fluoride ☐ Other

Check the statement that most applies to you…

1. My mouth is:
   - ☐ Very Comfortable
   - ☐ Moderately Comfortable
   - ☐ Uncomfortable
2. ☐ I think the appearance of my mouth is excellent.
   - ☐ I am satisfied with the appearance of my mouth.
   - ☐ I am dissatisfied with the appearance of my mouth.
3. ☐ I have put dentistry for myself and family high on my priority list.
   - ☐ I have put dentistry for myself and my family low on my priority list.
   - ☐ Dentistry is on my list but it's hard to find.
4. I think my present state of dental health is:
   - ☐ Excellent
   - ☐ Good
   - ☐ Poor

Are you having discomfort at this time?

☐ Yes ☐ No

Does dental treatment make you nervous?

☐ No ☐ Slightly ☐ Moderately ☐ Extremely

Have you ever had any serious trouble associated with previous dentistry?

☐ Yes ☐ No

Have you ever been treated for periodontal disease?

☐ Yes ☐ No

What are some questions about dentistry and your oral health that you never had adequately answered?

_____

_____

What is your main concern about your teeth?

_____

_____

Place a mark on "yes" or "no" to indicated if you have ever had any of the following…

Mouth		
Bleeding, Sore Gums	☐ Yes	☐ No
Unpleasant Taste/Bad Breath	☐ Yes	☐ No
Burning Tongue/Lips	☐ Yes	☐ No
Frequent Blister, Lips/Mouth	☐ Yes	☐ No
Swelling/Lumps in Mouth	☐ Yes	☐ No
Orthodontic Treatments (Braces)	☐ Yes	☐ No
Biting Cheeks/Lips	☐ Yes	☐ No
Clicking/Popping Jaw	☐ Yes	☐ No
Difficulty Opening/Closing Jaw	☐ Yes	☐ No

Teeth		
Loose Teeth	☐ Yes	☐ No
Sensitivity to Cold	☐ Yes	☐ No
Sensitivity to Heat	☐ Yes	☐ No
Sensitivity to Sweets	☐ Yes	☐ No
Sensitivity to Biting	☐ Yes	☐ No
Food Impaction	☐ Yes	☐ No
Clenching/Grinding	☐ Yes	☐ No

If so, when: _____

Do you use tobacco? ☐ Chew ☐ Smoke

How often? _____ How long? _____

Have you been under the care of a medical doctor during the past two years? ☐ Yes ☐ No

If yes, for what? _____

Physician's Name: _____

Last Visit to Physician: _____

Are you allergic or have you had a reaction to the following…

Local Anesthetic	☐ Yes	☐ No
Penicillin or Other Antibiotics	☐ Yes	☐ No
Aspirin, Ibuprofen or Tylenol	☐ Yes	☐ No
Codeine, Valium® or Other Sedatives	☐ Yes	☐ No
Latex or Metals	☐ Yes	☐ No

Have you ever had an allergic or adverse reaction to any medication or substance (including foods)?

☐ Yes ☐ No

If yes, please list:

Are you taking any medications, drugs or pills? ☐ Yes ☐ No

If yes, please list name and dosage:

Check yes or no to indicate whether or not you have had or now have the following conditions or treatments:

Heart Condition	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Arthritis/Rheumatism	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No	Tuberculosis (T.B.)	☐ Yes	☐ No	Special or Restricted Diet	☐ Yes	☐ No
Heart Surgery	☐ Yes	☐ No	Asthma	☐ Yes	☐ No	Latex Sensitivity	☐ Yes	☐ No
Chest Pain (Angina)	☐ Yes	☐ No	Hay Fever	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Congenital Heart Disease	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No	Tumors	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Allergies or Hives	☐ Yes	☐ No	Chemotherapy	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Radiation Therapy	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No	Hepatitis Type _____	☐ Yes	☐ No	Neurological Disorders	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No	Yellow Jaundice	☐ Yes	☐ No	Nervous/Anxious	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	AIDS	☐ Yes	☐ No	Epilepsy or Seizures	☐ Yes	☐ No
Heart Pacemaker	☐ Yes	☐ No	HIV Positive	☐ Yes	☐ No	Fainting or Dizzy Spells	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No	Psychiatric/Psychological Care	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No	Cold Sores/Fever Blisters	☐ Yes	☐ No	Alzheimer's/Dementia	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Blood Transfusion	☐ Yes	☐ No	Kidney Trouble	☐ Yes	☐ No
Drug Addiction	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No	Bone Disease or Bone Cancer	☐ Yes	☐ No
Family History of Diabetes	☐ Yes	☐ No	Cortisone Medicine	☐ Yes	☐ No	Artificial Joints	☐ Yes	☐ No

- Which Joints

- When

Any disease, condition or problem not listed:

Dr's comments:

Women

Are you pregnant or planning a pregnancy? ☐ Yes ☐ No Are you a nursing mother? ☐ Yes ☐ No

If yes, due date:

Patient Information

Patient

First: _____ Nickname: _____

Last: _____

Social Security Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Work: _____ Cell: _____

Email: _____

Gender: ☐ Male ☐ Female

Age: _____ Birthdate: _____

Parent/Guardian: _____

Insurance

Subscriber's Name: _____

Relationship: _____ Date of Birth: _____

Social Security Number: _____

Employer: _____

Insurance Company: _____

Group #: _____

Address: _____

City: _____ State: _____ Zip: _____

Dual Coverage: ☐ Yes ☐ No *If yes please complete the following*

Subscriber's Name: _____

Relationship: _____ Date of Birth: _____

Social Security Number: _____

Employer: _____

Insurance Company: _____

Group #: _____

Address: _____

City: _____ State: _____ Zip: _____

Employment/School

Occupation: _____

Employer/School: _____

Spouse's name: _____

Employer: _____

Referrals

Who can we thank for the referral?

_____

Consent

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, for a specialist referral, to obtain payment, and for those activities and health care operations that are related to treament or payment.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

I understand that my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts.

_____

Signature of Patient or Guardian

_____

Date