

## Patient Health Information Age \_\_\_\_\_

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Reason for today's visit \_\_\_\_\_

Former Dentist \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Date of last exam \_\_\_\_\_ Date of last dental x-rays \_\_\_\_\_ Last Panorex \_\_\_\_\_

Are you having pain when eating hot or cold food or drink? Y or N

Do you have pain when biting on hard or crunchy foods? Y or N

Do you have pain that is **throbbing** or awakens you from your sleep? Y or N

How often do you brush your teeth? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

Please check any of the following that apply to you:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Bad Breath                  | <input type="checkbox"/> Old fillings                         | <input type="checkbox"/> Sensitivity to cold   |
| <input type="checkbox"/> Bleeding Gums               | <input type="checkbox"/> Broken fillings                      | <input type="checkbox"/> Sensitivity to hot    |
| <input type="checkbox"/> Periodontal Disease         | <input type="checkbox"/> Loose teeth                          | <input type="checkbox"/> Sensitivity to biting |
| <input type="checkbox"/> Clicking or popping jaw     | <input type="checkbox"/> Periodontal cleanings                | <input type="checkbox"/> Sores in mouth        |
| <input type="checkbox"/> Food collects between teeth | <input type="checkbox"/> Periodontal surgery                  | <input type="checkbox"/> Smoker                |
| <input type="checkbox"/> Grinding or clenching teeth | <input type="checkbox"/> Snoring habit                        | <input type="checkbox"/> Chewing tobacco       |
| <input type="checkbox"/> Broken teeth                | <input type="checkbox"/> Soda pop habit (more than 1 per day) |  |
| <input type="checkbox"/> Crowns/Bridges              | <input type="checkbox"/> Implants                             | <input type="checkbox"/> Dentures              |
| <input type="checkbox"/> Removable Partial denture   | <input type="checkbox"/> Veneers                              | <input type="checkbox"/> Broken jaw/surgery    |
| <input type="checkbox"/> Wisdom teeth surgery        | <input type="checkbox"/> Tooth Trauma                         | <input type="checkbox"/> Jaw pain              |
| <input type="checkbox"/> Bite/Occlusion concerns     | <input type="checkbox"/> Bleeding problems                    | <input type="checkbox"/> Esthetic concerns     |

## Medical Information

Physician \_\_\_\_\_ Telephone \_\_\_\_\_

Do you have any allergies OR intolerances to medication or latex? \_\_\_\_\_

Please list any medications you are taking \_\_\_\_\_

Are you pregnant? Y or N    Nursing? Y or N    Taking birth control pills? Y or N

Date last seen by physician \_\_\_\_\_

Do you have a bleeding disorder or take a medication that causes prolonged bleeding? \_\_\_\_\_

Explain: \_\_\_\_\_

Do you have or have you had any of the following problems?

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> AIDS/HIV +              | <input type="checkbox"/> Cough, persistent | <input type="checkbox"/> Hepatitis A/B/C/E     |
| <input type="checkbox"/> Alcoholism              | <input type="checkbox"/> COPD              | <input type="checkbox"/> Hemophilia            |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Cough up blood    | <input type="checkbox"/> High blood pressure   |
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Kidney disease        |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Drug use/abuse    | <input type="checkbox"/> Liver disease         |
| <input type="checkbox"/> Artificial Joints       | <input type="checkbox"/> Epilepsy          | <input type="checkbox"/> Mitral valve prolapse |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> GERD/Reflux       | <input type="checkbox"/> Nervous problems      |
| <input type="checkbox"/> Back problems           | <input type="checkbox"/> Glaucoma          | <input type="checkbox"/> Pacemaker             |
| <input type="checkbox"/> Blood disease           | <input type="checkbox"/> Headaches         | <input type="checkbox"/> Psychiatric care      |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Heart Murmur      | <input type="checkbox"/> Radiation Treatment   |
| <input type="checkbox"/> Chemical Dependency     | <input type="checkbox"/> Heart Problems    | <input type="checkbox"/> Respiratory Disease   |
| <input type="checkbox"/> Chemotherapy            | <input type="checkbox"/> Tuberculosis      | <input type="checkbox"/> Stroke                |
| <input type="checkbox"/> Circulatory problems    | <input type="checkbox"/> Thyroid Problems  | <input type="checkbox"/> Ulcers (gastric)      |

## Other pertinent health information

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### Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist and Powell Dental Group to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that the filing of the insurance by the service provider is considered a service benefit and not a requirement of Powell Dental Group. I understand that Powell Dental Group will only submit to primary and secondary insurance providers. I understand that I am personally responsible for understanding and utilizing my dental benefits described per my insurance plan and Powell Dental Group will only assist me in interpreting these benefits from information provided to them by my insurance carrier.

**X**

\_\_\_\_\_  
SIGNATURE OF PATIENT /GUARDIAN  
OR PARENT/GUARDIAN IF PATIENT IS A MINOR

\_\_\_\_\_  
DATE