Pine Ridge Dental

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New Patient Health History Form

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Email:	Today's Date:

Name:		Home Phone: ( )		Business/Cell Phone: ( )	
Address:		City:		State:	Zip:
Occupation:		Height:	Weight:	Date of birth:	Sex: M F
SS # or Patient ID:	Emergency Contact:	Relationship:	Home Phone: ( )	Cell Phone: ( )	
If you are completing this form for another person, what is your relationship to that person? Your Name:			Relationship:		

Do you have ANY of the following diseases or problems:	***Check DK if you Don't Know the answer to the question***	**Yes**	**No**	**DK**
Active Tuberculosis		☐	☐	☐
Persistent Cough greater than a 3 week duration		☐	☐	☐
Cough that produces blood		☐	☐	☐
Been exposed to anyone with tuberculosis		☐	☐	☐
If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.				

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	**No**	**DK**		**Yes**	**No**	**DK**
Do your gums bleed when you brush or floss?	☐	☐	☐	Do you have earaches or neck pains?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐	Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐	Do you brux or grind your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐	Do you have sores or ulcers in your mouth?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐	Do you wear dentures or partials?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐	Do you participate in active recreational activities?	☐	☐	☐
Have you had any problems associated with previous dental treatment? Please explain:	☐	☐	☐	Have you ever had a serious injury to your head or mouth?	☐	☐	☐
				Date of your last dental exam: _____ What was done at that time?			
Is your home water supply fluoridated?	☐	☐	☐				
Do you drink bottled or filtered water?	☐	☐	☐				
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY				Date of last dental x-rays:			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐				
What is the reason for your dental visit today?							
How do you feel about your smile?							

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	**No**	**DK**		**Yes**	**No**	**DK**
Are you now under the care of a physician?	☐	☐	☐	Have you had serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐
Physician Name	Phone: ( )			If yes, what was the illness or problem?			
Address/City/State/Zip:				Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐
Are you in good health?	☐	☐	☐				
Has there been any change your general health within the past year?	☐	☐	☐	If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements?			
If yes, what condition is being treated?							
Date of last physical exam:							

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

Check DK if you Don't Know the answer to the question	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? Date: _____ If yes, have you had any complications? ____	☐	☐	☐
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began: _____			

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)? If so, how interested are you in stopping? (Circle One) VERY / SOMEWHAT / NOT INTERESTED	☐	☐	☐
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies. Are you allergic to or have you had a reaction to:	Yes	No	DK
To all **yes** responses, specify type of reaction.			
Local anesthetics	☐	☐	☐
Aspirin	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐	☐
Sulfa drugs	☐	☐	☐
Codeine or other narcotics	☐	☐	☐

	Yes	No	DK
Metals	☐	☐	☐
Latex (rubber)	☐	☐	☐
Iodine	☐	☐	☐
Hay Fever/seasonal	☐	☐	☐
Animals	☐	☐	☐
Food	☐	☐	☐
Other	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damages valves in transplanted heart	☐	☐	☐
Congenital heart diseases (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐
Except for the conditions listed above, antibiotic prophylaxis is no longer are recommended for any other form of CHD			

	Yes	No	DK
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer / Chemotherapy / Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux / persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐

	Yes	No	DK
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: _____			
Sleep disorder	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify: _____			
Recurrent infections	☐	☐	☐
Type of infection: _____			
Kidney Problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches / migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

	Yes	No	DK		Yes	No	DK
Cardiovascular disease	☐	☐	☐	Mitral valve prolapse	☐	☐	☐
Angina	☐	☐	☐	Pacemaker	☐	☐	☐
Arteriosclerosis	☐	☐	☐	Rheumatic fever	☐	☐	☐
Congestive heart failure	☐	☐	☐	Rheumatic heart disease	☐	☐	☐
Damaged heart valves	☐	☐	☐	Abnormal bleeding	☐	☐	☐
Heart attack	☐	☐	☐	Anemia	☐	☐	☐
Heart murmur	☐	☐	☐	Blood transfusion	☐	☐	☐
Low blood pressure	☐	☐	☐	If yes, date: _____			
High blood pressure	☐	☐	☐	Hemophilia	☐	☐	☐
Other congenital heart defects	☐	☐	☐	AIDS or HIV infection	☐	☐	☐
				Arthritis	☐	☐	☐
Stroke	☐	☐	☐	Glaucoma	☐	☐	☐

	Yes	No	DK
Has a physician or previous dentist recommend that you take antibiotics prior to your dental treatment?	☐	☐	☐
Name of physician or dentist making recommendation:	Phone: ( )		
Do you have any disease, condition, or problem not listed above that you think I should know about?	☐	☐	☐
Please explain:			

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian:	**Date:**

FOR COMPLETION BY DENTIST

Comments: _____