In-Home Dental Care

OFFICE USE ONLY
Patient Name: ____________
Pt. #: ____________

Physician's Name ____________________ Physician Phone ____________________
Address ______________________________ City ______________ State ______

Place a mark in the box for "**Yes**" or "**No**" to indicate if you have or have had any of the following:

	Yes	No		Yes	No		Yes	No
AIDS	☐	☐	Epilepsy or Seizures	☐	☐	Psychiatric Care	☐	☐
Anemia	☐	☐	Fainting or Dizziness	☐	☐	Radiation Treatment	☐	☐
Arthritis	☐	☐	Glaucoma	☐	☐	Respiratory Disease	☐	☐
Artificial Joints	☐	☐	Headaches	☐	☐	Rheumatic Fever	☐	☐
Asthma	☐	☐	Heart Murmur	☐	☐	Scarlet Fever	☐	☐
Back or Neck Problems	☐	☐	Hepatitis: Type ____	☐	☐	Shortness of Breath	☐	☐
Bleeding abnormally	☐	☐	Herpes	☐	☐	Sinus Trouble	☐	☐
Blood Disease	☐	☐	High Blood Pressure	☐	☐	Skin Rash	☐	☐
Cancer	☐	☐	HIV Positive	☐	☐	Stroke	☐	☐
Chemical Dependency	☐	☐	Jaw Joint Pain	☐	☐	Swelling of Feet or Ankles	☐	☐
Circulatory Problems	☐	☐	Kidney Disease	☐	☐	Swollen Neck Glands	☐	☐
Congenital Heart Lesions	☐	☐	Liver Disease	☐	☐	Thyroid Disease	☐	☐
Cortisone/Steroid Treatments	☐	☐	Mitral Valve Prolapse	☐	☐	Tonsillitis	☐	☐
Cough, persistent or bloody	☐	☐	Nervousness/Depression	☐	☐	Tuberculosis	☐	☐
Diabetes	☐	☐	Pacemaker	☐	☐	Ulcers	☐	☐
Taken the Diet Pill Fen-Phen?	☐	☐	Heart Conditions	☐	☐	Venereal Disease	☐	☐
Emphysema	☐	☐	Alcohol Use	☐	☐	Weight Loss, unexplained	☐	☐
			Bruise Easily	☐	☐			
Tumor or growth on head or neck	☐	☐	Tobacco Use	☐	☐	Are you pregnant	☐	☐
Artificial Heart Valves	☐	☐	Low Blood Pressure	☐	☐			
Angina (Chest Pain)	☐	☐	Snoring	☐	☐	Have you ever taken Fosamax, Zometa, Aredia or Actonel	☐	☐

MEDICATIONS

List medications ______________________________
____
____
____

Pharmacy Name ______________________________
Phone ____________________

ALLERGIES

☐ Aspirin ☐ Latex
☐ Barbiturates ☐ Penicillin
☐ Codeine ☐ Sulfa
☐ Iodine ☐ Metal
☐ Local Anesthetic ☐ Acrylic
☐ Other ____________________

DENTAL HISTORY

Are you currently under treatment/care with a dentist or dental office? ☐ Yes ☐ No
If **Yes**:
Dentist Name ____________________
City/State ____________________
Date of last dental visit ______________

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

	Yes	No
Bad breath	☐	☐
Bleeding gums	☐	☐
Blisters on lips or mouth	☐	☐

	Yes	No		Yes	No
Burning sensation tongue	☐	☐	Mouth breathing	☐	☐
Clicking or popping jaw	☐	☐	Mouth pain, brushing	☐	☐
Dry mouth	☐	☐	Orthodontic treatment	☐	☐
Fingernail biting	☐	☐	Pain around ear	☐	☐
Food collection between the teeth	☐	☐	Periodontal treatment	☐	☐
Grinding teeth	☐	☐	Sensitivity to cold	☐	☐
Gums swollen or tender	☐	☐	Sensitivity to heat	☐	☐
Jaw pain or tiredness	☐	☐	Sensitivity to sweets	☐	☐
Lip or cheek biting	☐	☐	Sensitivity when biting	☐	☐
Chew on one side of the mouth	☐	☐	Sores or growths in your mouth	☐	☐
Loose teeth or broken fillings	☐	☐	Do you brush your tongue?	☐	☐
How often do you Brush per day?	___		How often do you floss per day?	___	

Patients Signature ______________________________ Date ______________
Guardian/Care Taker ______________________________

Reviewed by: ______________
Date: ______________