

Indian Valley Dental Associates

601 E. Broad Street • Souderton, PA 18964

215-723-5531

PATIENT HEALTH RECORD

In order to help us render the proper dental services to you, would you please be kind enough to answer the following questions. Please note the space for remarks for any answers that require clarification or any other information you think we should have. Thank you for your cooperation.

Date _____				
Name (Last)	(First)	(Middle)	(Preferred)	
Address		City	State	Zip
Home Phone		Cell #		
E-mail	Employer	Business Address	Business Phone	
Date of Birth	Sex	Height	Weight	Occupation
Social Security No.		Who may we thank for referring you to our office?		
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Life Partner _____ Spouse's Name				

MEDICAL HEALTH

General Health: Excellent Good Fair Poor

Name and Address of Physician: _____

Last Complete Physical? _____

Are you taking any medication now? Yes No For what purpose? _____

Prescriptions or Over-the-Counter Medications (including fluoride): _____

Do you require premedication for dental procedures? Yes No Reason? _____

HAVE YOU EVER BEEN TREATED FOR?

Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tuberculosis or Lung Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No
AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint Replacement	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No

Are you allergic to: Penicillin Codeine Local injected anesthetics Latex Other _____

Are you subject to prolonged bleeding? Yes No

Have you ever taken the drug PhenPehn? Yes No

Have you ever taken Fosamax, Actonel, Bisphosphonates. Yes No

Women: Are you pregnant? Yes No

Do you take birth control pills? Yes No

Due Date: _____

During the course of treatment, local anesthetic ("novocaine") may have to be used to avoid pain. Possible side effects, while not expected, could include, but not be limited to: prolonged numbness, infections, difficulty of opening, short periods of excitability, bleeding, muscle soreness, biting lip or tongue, or unknown allergic reactions.

DENTAL HEALTH

Reason for visit: _____

When was your last dental visit? _____ Previous Dentist _____

Have you ever had any serious problem associated with previous dental treatment? Yes No If Yes, Please Explain _____

How often do you brush your teeth? _____

How often do you floss? _____

Do your gums bleed while brushing? Yes No

Do your gums bleed while flossing? Yes No

Do your gums feel tender or swollen? Yes No

Do you clench or grind your jaws while sleeping or during the day? Yes No

Do you smoke or use tobacco products? Yes No

Are you happy with your smile? Yes No

If No, explain _____

Please add anything you feel is important: _____

Patient/Guardian Signature