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 Occupation

Social Security No. Who may we thank for referring you to our office?

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Life Partner Spouse's Name

MEDICAL HEALTH

General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name and Phone of Physician:____________________

Pharmacy Name and Phone:____________________

Are you taking any medication now? ☐ Yes ☐ No List all Prescriptions or Over-the-Counter Medications (including Fluoride)__________

Do you require premedication for dental procedures? ☐ Yes ☐ No Reason?__________

HAVE YOU EVER BEEN TREATED FOR?

Condition		Condition	
Heart Disease	☐ Yes ☐ No	Anxiety/ Depression	☐ Yes ☐ No
Rheumatic Fever	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No
Stomach Ulcers	☐ Yes ☐ No	Asthma or Hay Fever	☐ Yes ☐ No
Tuberculosis or Lung Disease	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Diabetes / Type:_____	☐ Yes ☐ No	Cancer / Type:_____	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Athritis	☐ Yes ☐ No
STD's	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
AIDS/HIV	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No
Thyroid Condition	☐ Yes ☐ No	Artificial Joint Replacement	☐ Yes ☐ No
		Alcohol / Drug Abuse	☐ Yes ☐ No

Are you allergic to: ☐ Penicillin ☐ Codeine ☐ Local injected anesthetics ☐ Latex ☐ Other__________

Are you subject to prolonged bleeding? ☐ Yes ☐ No

Do you smoke or use tobacco products? ☐ Yes ☐ No

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

Women: Are you pregnant? ☐ Yes ☐ No Due Date:__________

Do you take birth control pills? ☐ Yes ☐ No

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: ______________________________

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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

Are you happy with your smile? ☐ Yes ☐ No

If No, explain ______________________________

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Please add anything you feel is important: ______________________________

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Patient/Guardian Signature