DENTAL HARMONY

Patient Information & Health History

Patient:

Date:

Referral information, how did you learn about us?

Brandon S. Elimanco DMD
Dental Harmony
www.dentalharmony.com

63 West Main Street
Freehold, NJ 07728
(732) 780-1400

Dental & Medical Health History

Note: Correct answers to the following questions will allow Dr. Brandon Elimanco and the Dental Harmony staff to treat you on a more individual basis, providing the care appropriate for your particular needs. It will allow Dental Harmony to treat you so there will not be an emergency. However, if an emergency situation does arise, this information will help insure proper treatment. Your answers are for our records only and will be considered confidential.

Date of Last Dental Visit: _____

How often do you brush your teeth? _____

My brush is… ☐ Soft ☐ Medium ☐ Hard

What other dental aids do you use?

☐ Brush ☐ Dental Floss ☐ Fluoride ☐ Other

Check the statement that most applies to you…

1. My mouth is:
   ☐ Very Comfortable ☐ Moderately Comfortable
   ☐ Uncomfortable
2. ☐ I think the appearance of my mouth is excellent.
   ☐ I am satisfied with the appearance of my mouth.
   ☐ I am dissatisfied with the appearance of my mouth.
3. ☐ I will do anything to keep my natural teeth.
   ☐ I want to keep my teeth, but I have a certain budget of time and money that I am willing to spend on them.
4. ☐ I have set goals for my oral health with a previous dentist.
   ☐ I want to set goals concerning my dental health.
5. ☐ I have always done the best that was recommended for my dental health.
   ☐ I have not done what dentists have recommended to me.
   ☐ I rarely go, and don't care much about having any dental work completed.
6. ☐ I have put dentistry for myself and family high on my priority list.
   ☐ I have put dentistry for myself and my family low on my priority list.
   ☐ Dentistry is on my list but it's hard to find.
7. I think my present state of dental health is:
   ☐ Excellent ☐ Good ☐ Poor

What are some questions about dentistry and your oral health that you never had adequately answered?

_____

_____

Are you having discomfort at this time? ☐ Yes ☐ No

Does dental treatment make you nervous?

☐ No ☐ Slightly ☐ Moderately ☐ Extremely

What do you fear most about dental care?

_____

_____

These things are important to me about my dental health…

_____

_____

Have you ever had any serious trouble associated with previous dentistry? ☐ Yes ☐ No

Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicated if you have ever had any of the following…

Mouth

Bleeding, Sore Gums	☐ Yes	☐ No
Unpleasant Taste/Bad Breath	☐ Yes	☐ No
Burning Tongue/Lips	☐ Yes	☐ No
Frequent Blister, Lips/Mouth	☐ Yes	☐ No
Swelling/Lumps in Mouth	☐ Yes	☐ No
Orthodontic Treatments (Braces)	☐ Yes	☐ No
Biting Cheeks/Lips	☐ Yes	☐ No
Clicking/Popping Jaw	☐ Yes	☐ No
Difficulty Opening/Closing Jaw	☐ Yes	☐ No

Teeth

Loose Teeth	☐ Yes	☐ No
Sensitivity to Cold	☐ Yes	☐ No
Sensitivity to Heat	☐ Yes	☐ No
Sensitivity to Sweets	☐ Yes	☐ No
Sensitivity to Biting	☐ Yes	☐ No
Food Impaction	☐ Yes	☐ No
Shifting in Bite	☐ Yes	☐ No
Change in Bite	☐ Yes	☐ No
Clenching/Grinding	☐ Yes	☐ No

If so, when: _____

Have you been under the care of a medical doctor during the past two years? ☐ Yes ☐ No

If yes, for what? _____

Physician's Name: _____

Last Visit to Physician: _____

Are you allergic or have you had a reaction to the following…

Local Anesthetic	☐ Yes	☐ No
Penicillin or Other Antibiotics	☐ Yes	☐ No
Aspirin, Ibuprofen or Tylenol	☐ Yes	☐ No
Codeine, Valium® or Other Sedatives	☐ Yes	☐ No
Latex or Metals	☐ Yes	☐ No

Have you ever had an allergic or adverse reaction to any medication or substance (including foods)? ☐ Yes ☐ No

If yes, please list: _____

_____

Do you have high blood pressure? ☐ Yes ☐ No

What is your normal blood pressure? _____

Are you taking any medications, drugs or pills? ☐ Yes ☐ No

If yes, please list name and dosage: _____

_____

_____

_____

Do you use tobacco? ☐ Chew ☐ Smoke

How often? _____ How long? _____

Do you consume alcohol? ☐ Yes ☐ No

How many beverages per week? _____

Do you use any mood altering drugs other than those previously listed? ☐ Yes ☐ No

Check yes or no to indicate whether or not you have had or now have the following conditions or treatments:

Heart Condition	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Arthritis/Rheumatism	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No	Tuberculosis (T.B.)	☐ Yes	☐ No	Fen-Phen or Redox	☐ Yes	☐ No
Heart Surgery	☐ Yes	☐ No	Asthma	☐ Yes	☐ No	Special or Restricted Diet	☐ Yes	☐ No
Chest Pain (Angina)	☐ Yes	☐ No	Hay Fever	☐ Yes	☐ No	Latex Sensitivity	☐ Yes	☐ No
Congenital Heart Disease	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Allergies or Hives	☐ Yes	☐ No	Tumors	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Chemotherapy	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No	Hepatitis Type _____	☐ Yes	☐ No	Radiation Therapy	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	Yellow Jaundice	☐ Yes	☐ No	Neurological Disorders	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No	AIDS	☐ Yes	☐ No	Nervous/Anxious	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	HIV Positive	☐ Yes	☐ No	Epilepsy or Seizures	☐ Yes	☐ No
Heart Pacemaker	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No	Fainting or Dizzy Spells	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Cold Sores/Fever Blisters	☐ Yes	☐ No	Psychiatric/Psychological Care	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No	Blood Transfusion	☐ Yes	☐ No	Kidney Trouble	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No	Artificial Joints	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Swollen Ankles	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
Drug Addiction	☐ Yes	☐ No	Cortisone Medicine	☐ Yes	☐ No	Bone Disease or Bone Cancer	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No						
Family History of Diabetes	☐ Yes	☐ No						
Artificial Joints	☐ Yes	☐ No						

Any disease, condition or problem not listed: _____

Dr's comments: _____

Women

Are you pregnant or planning a pregnancy? ☐ Yes ☐ No

If yes, due date: _____

Are you a nursing mother? ☐ Yes ☐ No

Are you taking birth control pills? ☐ Yes ☐ No

Patient Information

Patient

First: _____ Last: _____

Middle Initial: _____ Nickname: _____

Social Security Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Work: _____ Cell: _____

Email: _____

Gender: ☐ Male ☐ Female

Age: _____ Birthdate: _____

Drivers License #: _____

Parent/Guardian: _____

Insurance

Subscriber's Name: _____

Relationship: _____ Date of Birth: _____

Social Security Number: _____

Employer: _____

Insurance Company: _____

Group #: _____

Address: _____

City: _____ State: _____ Zip: _____

Dual Coverage: ☐ Yes ☐ No *If yes please complete the following*

Subscriber's Name: _____

Relationship: _____ Date of Birth: _____

Social Security Number: _____

Employer: _____

Insurance Company: _____

Group #: _____

Address: _____

City: _____ State: _____ Zip: _____

Employment/School

Occupation: _____

Employer/School: _____

How long: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Spouse's name: _____

Employer: _____

How long: _____

Emergency Notification

Name: _____

Relationship: _____

Phone: _____

Consent

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care. I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treament or payment. I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care. My consent to disclosure of records shall be effective until I revoke it in writing. I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor. I attest to the accuracy of the information on this page.

_____

Signature of Patient or Guardian

_____

Date