



# DENTAL HARMONY

## PATIENT INFORMATION & HEALTH HISTORY

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Patient:

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Date:

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Referral information, how did you learn about us?

# 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	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Unpleasant Taste/Bad Breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Burning Tongue/Lips	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Frequent Blister, Lips/Mouth	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Swelling/Lumps in Mouth	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Orthodontic Treatments (Braces)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Biting Cheeks/Lips	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Clicking/Popping Jaw	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Difficulty Opening/Closing Jaw	<input type="checkbox"/> Yes	<input type="checkbox"/> No

## Teeth

Loose Teeth	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sensitivity to Cold	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sensitivity to Heat	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sensitivity to Sweets	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sensitivity to Biting	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Food Impaction	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shifting in Bite	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Change in Bite	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Clenching/Grinding	<input type="checkbox"/> Yes	<input type="checkbox"/> 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	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Penicillin or Other Antibiotics	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Aspirin, Ibuprofen or Tylenol	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Codeine, Valium® or Other Sedatives	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Latex or Metals	<input type="checkbox"/> Yes	<input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis/Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis (T.B.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fen-Phen or Redox	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special or Restricted Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pain (Angina)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Latex Sensitivity	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	Allergies or Hives	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis Type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Yellow Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neurological Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous/Anxious	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy or Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or Dizzy Spells	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cold Sores/Fever Blisters	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric/Psychological Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood Transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drug Addiction	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cortisone Medicine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bone Disease or Bone Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Family History of Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No				

Any disease, condition or problem not listed: \_\_\_\_\_

Dr's comments: \_\_\_\_\_

**Women**

Are you pregnant or planning a pregnancy?  Yes  No Are you a nursing mother?  Yes  No

If yes, due date: \_\_\_\_\_ 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 treatment 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