MOUNTAIN VIEW DENTAL

PATIENT INFORMATION AND HEALTH HISTORY

Date: _____ Name *(First and Last)*: _____ Middle Initial: _____

Nickname/Preferred Name: _____ SSN: _____-_____-_____ DL #: _____

Home Phone: (_____)_____ Cell: (_____)_____ EMAIL: _____

Street Address: _____ City: _____ State: ___ Zip: _____

Mailing Address (if different from above): _____

Date of Birth: _____ Sex: ☐ M ☐ F Occupation/Employer: _____

Preferred Pharmacy: _____

Emergency Contact: _____ Phone Number: _____ Relation: _____

Who referred you to our office (or how did you hear about us)? _____

Bonus Question: Tell us a fun fact about you: _____

Insurance Information

Primary Dental Insurance: _____ Subscriber ID: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Relationship to Patient: _____

Secondary Dental Insurance: _____ Subscriber ID: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Relationship to Patient: _____

Getting to know you

What is most important to you about the dental care you receive?

If you could change something about your smile, what would it be?

Check One: When we present information to you, do you prefer
□ BIG PICTURE
□ DETAILS

Check One: When there is something to be done, do you tend to
□ WAIT until a problem arises or
□ HANDLE IT BEFORE there is a crisis?

Dental Information

Yes	No	Unknown	
□	□	□	Do your gums bleed when you brush?
□	□	□	Have you ever had orthodontic treatment?
□	□	□	Do you have headaches, earaches or neck pain?
□	□	□	Have you been told you have gum disease?
□	□	□	Are you aware of loose teeth or broken fillings?
□	□	□	Are your gums swollen or tender?
□	□	□	Are you a mouth breather?
□	□	□	Do you frequently get blisters on lips or mouth?
□	□	□	Do you ever get a burning sensation on tongue?
□	□	□	Do you chew on one side of your mouth?
□	□	□	Do you experience clicking/popping in your jaw?
□	□	□	Do you get jaw pain or fatigue?
□	□	□	Does food collect between your teeth?
□	□	□	Do you have pain when brushing?
□	□	□	Do you grind your teeth?
□	□	□	Do you wear a nightguard, denture(s) or removable appliance?

Circle One: Are your teeth sensitive to COLD, HOT, SWEETS or PRESSURE?

Have you had any problems associated with previous dental treatment or past dental experiences?

How often do you clean between your teeth? _____
How often do you brush? _____**/day**
How often do you have dental check ups? _____

Oral Habits (*Check all that apply*)
□ Tongue/lip piercing
□ Using teeth as a tool
□ Bite nails or other objects
□ Musical instruments with mouthpiece

Which fluoride products do you use/consume?
□ Toothpaste □ Water □ Rinses □ None □ Other_____

Medical Information

Physician(s): _____ Phone: (_____)_____
Name of Clinic: _____ City: _____

Yes	No	Unknown	
□	□	□	Are you in good health?
□	□	□	Have there been any changes in your health within the past year?
□	□	□	Are you under the care of a physician? If so, what are the conditions being treated? _____
□	□	□	Have you had any serious illness, operation or been hospitalized in the past 5 years? If so, what was the illness or health concern? _____
□	□	□	Do you consume snacks/beverages containing sugar between meals?
□	□	□	Do you snore?
□	□	□	Do you wake up feeling refreshed?
□	□	□	Have you ever been told you have sleep apnea?
□	□	□	Have you ever worn a CPAP? If yes, do/did you use it regularly? Explain: _____

What is your alcohol consumption history?
□ None, I don't drink at all
□ Light drinker: Consumed less than 3 drinks per week on average
□ Moderate drinker: Consumed 3 to 14 drinks per week on average in past year
□ Heavy drinker: Consumed 2 to 3 drinks per day on average in past year

What is your history of tobacco use?
□ Never smoked
□ Current smoker, _____ pack(s) per _____
□ Former smoker, Age Began: _____ Year Quit: _____

Recreational Drug Use
□ NONE
□ Marijuana; what method (*smoke, edibles, etc*): _____
□ Other: _____

Smokeless tobacco use
□ Never used smokeless tobacco
□ Current tobacco chewer
□ Former tobacco chewer, Year Quit: _____
□ Current vape user
□ Former vape user

Are you taking any medications (Prescription or Over-the-Counter)?

Name of Drug	Purpose

Are you allergic to or have you had a reaction to:

Yes	No	Unknown	
□	□	□	Local anesthetics
□	□	□	Penicillin or other antibiotics
□	□	□	Barbiturates, sedatives or sleeping pills
□	□	□	Sulfa drugs
□	□	□	Codeine or other narcotics
□	□	□	Latex
□	□	□	Iodine
□	□	□	Hay fever/seasonal
□	□	□	Metal

Please list any drugs or medicines that you cannot or prefer to not take because of allergies or side-effects, especially antibiotics for infections, analgesics for pain, and anesthetics: _____

What is your preferred drug for mild and/or severe pain? _____

PLEASE (X) A RESPONSE TO INDICATE IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS

Yes	No	Unknown	
□	□	□	Abnormal Bleeding Controlled? (*circle one*) Good Fair Poor
□	□	□	AIDS or HIV
□	□	□	Anemia
□	□	□	Herpes
□	□	□	Arthritis
□	□	□	Rheumatoid Arthritis
□	□	□	Asthma
□	□	□	Blood transfusion If yes, date: _____
□	□	□	Cancer/chemotherapy/radiation
□	□	□	Cardiovascular diseases? □ Angina Pectoris □ Heart Murmur □ Bypass Surgery □ Mitral Valve Prolapse □ Pacemaker □ Rheumatic Fever □ Artificial Valves □ Stents □ Heart Attack Date: _____
□	□	□	Chest pain/shortness of breath upon exertion
□	□	□	Chronic pain
□	□	□	GE reflux, persistent heartburn, or GI disease
□	□	□	Hemophilia
□	□	□	Hepatitis, jaundice or liver disease
□	□	□	High/Low blood pressure
□	□	□	Recurrent infection Type:_____
□	□	□	Diabetes
□	□	□	Epilepsy
□	□	□	Fainting spells or seizures
□	□	□	Dry mouth
□	□	□	Joint replacement date: _____
□	□	□	Eating disorder If yes, please specify: _____

Yes	No	Unknown	
□	□	□	Immunosuppression
□	□	□	Mental health disorder Type: _____
□	□	□	Neurological disorders Type:_____
□	□	□	Night sweats/Menopausal
□	□	□	Osteoporosis
□	□	□	Persistent swollen glands
□	□	□	Respiratory problems If yes, please specify: _____
□	□	□	Severe headaches/migraines
□	□	□	Sexually transmitted disease
□	□	□	Sinus trouble
□	□	□	Sores or ulcers in the mouth
□	□	□	Stroke If yes, date: _____
□	□	□	Systemic Lupus Erythematosus
□	□	□	Tuberculosis
□	□	□	Thyroid problems
□	□	□	Ulcers
□	□	□	Excessive urination/thirst
□	□	□	Have you ever been told you needed to pre-medicate for dental treatment?
□	□	□	Are you pregnant?

Do you have any condition not listed above that you think we should know about?

Please feel free to add any additional information you would like us to know about your medical or dental care:

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any other member of his staff responsible for any action they take because of errors or omission that I may have made in the completion of this form.

_____ _____

Signature of Patient/Legal Guardian Date

--BELOW: IN OFFICE USE ONLY --

I HAVE REVIEWED THE ATTACHED MEDICAL/DENTAL HISTORY AND HAVE NOTED ANY CHANGES

Date ______________________ Comments/Changes ______________________

Signature of patient (or guardian) ______________________ Signature of Dentist/Hygienist ______________________

Date ______________________ Comments/Changes ______________________

Signature of patient (or guardian) ______________________ Signature of Dentist/Hygienist ______________________

Date ______________________ Comments/Changes ______________________

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