SOUTH FLORIDA SMILE SPA, NICOLE M. BERGER, D.D.S., P.A.

PATIENT HEALTH RECORD

PLEASE PRINT

Date_____Soc. Sec. No._____

Name_____
(LAST) (FIRST) (MIDDLE)
Name you wished to be called_____
Home Address_____
(STREET) (CITY) (STATE) (ZIP)
Home Phone_____Business Phone_____ Cell_____
Date of Birth_____ E-MaiAddress_____
Sex_____ Height_____Weight_____ Single_____Married_____Widowed_____Divorced_____
Occupation_____Place of Employment_____
Spouse's Name_____Date of Birth_____Business Phone_____
Spouse's Occupation_____Place of Employment_____
Dental Insurance Company_____Policy #_____Member#_____
Closest Relative_____ Phone_____
Who Recommended Our Office?_____ Most Convenient Time for Appointment_____
Person Responsible for Account_____ Drivers License_____

MEDICAL HEALTH INFORMATION

Name and address of Physician_____
Are you taking any medications? Yes No For What Purpose?_____
List Medications_____ _____
_____ _____

Have you ever been treated for:

Heart Disease.....Yes....No
Rheumatic Fever.....Yes.... No
Abnormal Blood Pressure.....Yes.... No
Heart Attack.....Yes.... No
Heart Valve Defect.....Yes.... No
Heart Valve Replacment.....Yes.... No
Heart Murmur.....Yes.... No
Hip Replacement.....Yes.... No
Ulcers.....Yes.... No
Tuberculosis.....Yes....No
Nervous Disorders.....Yes....No
Lung Disease.....Yes....No
Venereal Disease.....Yes.... No
Thyroid Disease.....Yes....No

Diabetes.....Yes....No
Epiliepsy.....Yes....No
Anemia.....Yes....No
Jaundice.....Yes....No
Asthma.....Yes....No
Sinus Trouble or Hay Fever.....Yes ...No
Cough..... Yes... No
Hepatitis.....Yes....No
AIDS/HIV.....Yes...No
Arthritis..... Yes...No
Stroke..... Yes...No
Psychiatric treatment..... .Yes... No
Cancer..... Yes....No
High Cholesterol.....Yes....No

Sleep apnea.....Yes....No

Are you Allergic to: Penicillin ..... Codiene..... Local Injected Anesthetics ..... Other.....

Have you received or are you currently receiving medication known as Bisphosponates.....Yes....No
(for example Zoledroinc acid (Zometa) or Pamidronate Aredia)
Have you noticed any changes in your mouth or jaw?.....Yes....No
Have you notice any foul smell, swelling or discharge in your mouth?.....Yes.... No
Have you ever had radiation treatment?.....Yes ....No
Are you subject to prolonged bleeding?.....Yes....No
Do you have trouble sleeping?.....Yes....No
Do you have problems with digestion?.....Yes...No
Do you smoke?.....Yes No How Much?.....
Have you had any serious operations in the last 5 years?.....Yes....No
Are you subject to fainting spells?.....Yes....No

Do you have excessive urination and/or thirst?..... ..Yes….No
Have you ever been told to take antibiotics before dental treatment?.....Yes….No

(WOMEN ONLY)

Are you pregnant?.....Yes No How long?.....
Do you have any problems associated with your menstrual period?.....Yes No
Do you have a poor appetite?.....Yes No

DENTAL HEALTH

Reason for visit?_____
When was your last dental visit?_____
Name and address of previous dentist_____
_____
Have you ever had any serious trouble associated with previous dental treatment?.....Yes No
if so, explain_____
_____
Do you have periodic dental checkups?.....Yes No
When did you last have your teeth professionally cleaned?_____
How often do you brush your teeth?_____
What texture brush do you use? **SOFT** **MEDIUM** **HARD** **NYLON** **NATURAL**
How often do you floss?_____
Do your gums bleed when brushing?.....Yes No
Do your gums bleed when flossing?.....Yes No
Do you avoid brushing any part of your mouth because of pain?.....Yes No
if yes, what part?_____
Do you feel twinges of pain when your teeth come in contact with: **HOT** **COLD** **SWEETS** **SOUR**
Do your gums feel tender or swollen?.....Yes No
Do you usually have many cavities?.....Yes No
Do you lose fillings or break fillings?..... Yes No
Are you usually nervous during dental visits?..... Yes No
Do you prefer local anesthetics during dental visits?.....Yes No
Do you gag easily?..... Yes No
Do you think you eat well-balanced meals?.....Yes No
How do you feel about the general condition of your teeth and gums?.....Yes No
_____
Are you familiar with the term “preventative dentistry”?.....Yes No
Do you have difficulty or pain, or both, when opening your mouth, as for instance, when yawning?.....Yes No
Does your jaw get “stuck”, “locked”, or “go out”?.....Yes No
Are you aware of noises in the jaw joints?.....Yes No
Do you have pain in or about the ears, temples or cheeks?.....Yes No
Does your bite feel uncomfortable or unusual?.....Yes No
Do you have frequent headaches?.....Yes No
If yes, how often?_____
Have you had a recent injury to your head, neck or jaw? (Automobile Accident).....Yes No
Have you previously been treated for a jaw joint problem (TMJ)?.....Yes No
If so, when?_____
Do you have any muscle or joint problems?.....Yes No
Please add anything you feel is important_____
_____

Patient Signature:_____ **Dentist Signature:**_____

Date:_____ **Date:**_____