TREATMENT RECORD

DATE: ____/____/____ (M / D / Y)

PATIENT IS AN ADULT ☐ CHILD ☐ ADULT UNDER GUARDIANSHIP ☐ NAME OF GUARDIAN: _____

Name _____ Nickname _____ Mrs. ☐ Ms ☐ Mr. ☐

Home Address _____

Home Phone _____ Cellular Phone _____ Fax# _____

Date of Birth _____ Age _____ Sex _____ Marital Status _____

Family Physician _____ Phone ( ) _____

Medical Specialist (if presently under care) _____ Phone ( ) _____

OCCUPATION

Employed By _____ Phone ( ) _____ Ext. _____

Spouse Employed By _____ Phone ( ) _____ Ext. _____

PERSON RESPONSIBLE FOR ACCOUNT SELF ☐ or OTHER ☐ Name _____

Address _____

Home Phone ( ) _____ Business Phone ( ) _____ Insurance Carrier _____

IN CASE OF EMERGENCY Please Notify _____ Relationship _____

Home Phone ( ) _____ Business Phone ( ) _____ Ext. _____

Is any other member of your family or relative a patient at our office?

REASON FOR TODAY'S VISIT Examination ☐ Emergency ☐ Other ☐

Please check YES or No. *If not sure, please check NS.*

	NO	NS	YES
Are you suffering from pain now?	☐	☐	☐
Are any of your teeth becoming loose?	☐	☐	☐
Are any teeth sensitive to: cold ☐ hot ☐ biting ☐ pressure ☐ sweet ☐ bitter ☐	☐	☐	☐
Is there a history of gum disease in your family?	☐	☐	☐
Do you notice any bleeding from your gums when you brush your teeth, or other?	☐	☐	☐
Have you had a local anesthetic (freezing)?	☐	☐	☐
...any complications?	☐	☐	☐
Have you had any teeth extracted?	☐	☐	☐
...any complications?	☐	☐	☐
Are you nervous about having dental treatment?	☐	☐	☐
Have you ever had an upsetting experience in a Dental Office?	☐	☐	☐

EXPLAIN:

ORAL HYGIENE	NO	NS	YES
Do you use Dental aids?	☐	☐	☐
Do you use any fluoride/mouth rinses?	☐	☐	☐
Are you happy with appearance of your teeth?	☐	☐	☐
What would you like to change about your teeth?			
How often do you brush your teeth?			
How often do you floss your teeth?			
JAW PROBLEMS	☐	☐	☐
Are you being followed-up by a dental specialist?	☐	☐	☐

TREATMENTS — Please check off the following treatments you have had:			
Orthodontic treatment (braces)?	☐	☐	☐
Oral surgery?	☐	☐	☐
Periodontal treatment (gum surgery)?	☐	☐	☐
Worn a bite plate or other appliance?	☐	☐	☐
Dental implants?	☐	☐	☐

MEDICAL ALERT	*CONDITION*	*PREMEDITATION*	*ALLERGIES*	*ANAESE.*

MEDICAL HISTORY	PLEASE CHECK YES OR NO. *IF NOT SURE, CHECK NS*	NO	NS	YES
	Are you currently in good health?			
	Have you been under Doctor's care in the past two years? Why?			
	Are you presently taking any medications, pills or drugs? Please write name: _____ _____ _____			
	Have you had any type of surgery? What & When?			
	Have you ever taken cortisone/steroid medication?			
	Do you experience problems with healing?			
	Do you smoke? (If yes, how much?)			
	Do you bruise easily or bleed excessively?			
	Have you ever been warned about anesthetic risks?			

ALLERGIES	PLEASE CHECK OFF ANY MEDICATIONS YOU ARE ALLERGIC TO OR YOU HAVE REACTED ADVERSELY TO:						
❑ Ibuprofen (Advil)		❑ Demerol	❑ Erythromycin	❑ Cedhalexin	❑ Local Anaesthic (Freezing)	❑ Rovamycin	❑ Bandage
❑ Aspirin		❑ Percodan	❑ Clindamycin	❑ Sulpha Drugs	❑ Nitrous Oxide	❑ Ampicillin	❑ Seconal
❑ Tylenol		❑ Darvon	❑ Scopolamine	❑ Metal	❑ Amoxicillin	❑ Valium	
❑ Tylenol #2, #3, #4		❑ Penicillin	❑ Tetracycline	❑ Latex	❑ Chlorhexidence (Peridex)	❑ Codeine	
❑ Food Allergies, please list:							
Please list any other medications or substances which you know you are allergiec to:							

MEDICAL CONDITIONS	PLEASE CHECK OFF ALL OF THE FOLLOWING CONDITIONS YOU HAVE, OR HAVE HAD. *IF NOT SURE, CHECK NS*											
	NO	NS	YES		NO	NS	YES		NO	NS	YES
Malignant Hyperthermia				Scarlet Fever				Rheumatic Fever			
Stomach/Intestinal Problems				Kidney Trouble				Artificial Joints/Hips			
Transdermal Nicotine Patches				Ulcers				Diabetes or Hypoglycemia			
High Blood Pressure/Hypertension				Asthma				Arthritis/Rheumatism			
Low Blood Pressure				Hay Fever				Epilepsy or Seizures			
Heart Failure				Sinus Trouble				Glandular Disorders			
Congenital Heart Lesion				Emphysema				Psychiatric Care			
Artificial Heart Valve				Frequent Cough				Mental/Nervous Disorder			
Heart Pacemaker				Lung Disease				AIDS (HIV V Positive)			
Heart Surgery				Bronchitis				Venereal Disease			
Heart Murmur				Tuberculosis				Herpes			
Mitral Valve Prolapse				Liver Disease				Cold Sores			
Chest Pain				Hepatitis A (infec.)				Fever Blisters			
Angina Pectoris				Hepatitis B (serum)				Blood Disorders			
Shortness of Breath				Hepatitis C				Circulation Problems			
Stroke				Yellow Jaundice				Sickle Cell Anemia			
Fainting or Dizziness				Thyroid Disease				Hemophilia			
Anemia				Glaucoma				Cancer			
Cardiac Arrest/Heart Attack				Pain in Jaw Joints				Chemotherapy/Radiation			
Swelling of Feet/Ankles/Hands				Head/Neck Injuries				X-Ray/Cobalt Treatment			
Drug or Alcohol Addiction				If Yes, have you received treatment				Where?			
Is there anything we have not mentioned that you think we should know regarding your medical history?											
Follow-up information to above questions:											

WOMEN ONLY					
	Are you pregnant?	YES ❑	NO ❑	Are you taking Birth Control Pills?	YES ❑ NO ❑
	Are you nursing?	YES ❑	NO ❑	Are you taking fertility drugs?	YES ❑ NO ❑

GENERAL PATIENT CONSENT FORM

I, _____ agree that The Dental House can collect, use and disclose my personal information as described in this agreement.
The purpose for collecting personal information is to enable our office to provide appropriate dental care. Your personal information will not be collected, used, disclosed or accessed except as provided for in our privacy code, in this consent form or where required by law. The specific ways in which our office will use and disclose your personal information are described in Appendix A.
I understand the information described above, and authorize the dental office/professional corporation noted above to collect, use and disclose my personal information as described.

Signature_____ Print Name _____ Date _____ Witness _____

_____ _____

I, the undersigned, hereby consent to all dental and surgical treatments that are deemed necessary or desirable, including the use of local anaesthetics.I assume the responsibility for payment of all fees from these treatments. I understand that it is my responsibility to inform this office of my change in my medical status.

Patient's (or parent's) signature:_____Date:_____