HEALTH HISTORY & REGISTRATION

PATIENT INFORMATION

DATE_____

NAME last _____ first_____ initial_____ sex M F Birthdate_____

SOC SEC# _____ If patient is a minor, parent or guardian name_____

ADDRESS street_____apt#_____ city_____ state_____ zip_____

HOME PHONE _____ WORK PHONE _____

MARITAL STATUS single married widowed divorced SPOUSE'S NAME_____

OCCUPATION_____

Referred by _____

Reason for visit _____

NAME OF PERSON RESPONSIBLE FOR ACCOUNT

NAME last _____ first_____ initial_____ Marital status_____

Residence street_____apt#_____ city_____ state_____ zip_____

Business address _____

Home phone_____ Work phone _____

Soc. Sec.#_____ Birthdate_____ Relationship to patient _____

Employer _____ Occupation_____

Do you have dental insurance? Yes No

EMERGENCY INFORMATION

(Relative not living with you)

Name _____ Relationship_____

Address _____Phone #_____

MEDICAL HISTORY

Do you have any current health problems? Yes____ No____ If yes, please specify _____

Physician name & address _____

What medications are you taking? _____

Are you pregnant? Yes____ No____ How long?_____

Do you use cigars/cigarettes, pipe or chewing tobacco? Yes____ No____

Circle any of the following which you have had or presently have.

heart disease or attack
angina pectoris
high blood pressure
heart murmur
rheumatic fever
congenital heart lesions
mitral valve prolapse
artificial heart valve
pacemaker
heart surgery

artificial joints (hip/knee)
anemia
AIDS (HIV POS)
hepatitis A (infectious)
hepatitis B (serum)
kidney trouble
ulcers
liver disease
drug addiction

hemophilia (bleeding problems)
epilepsy/seizures
chemotherapy
(cancer/leukemia)
venereal disease
stroke
emphysema
tuberculosis
asthma
hay fever

sinus trouble
allergies/hives
diabetes
thyroid disease
radiation treatment
arthritis
cortisone medicine
high cholesterol
cancer

Are you allergic to or have reacted adversely to any of the following medications?

penicillin erythromycin aspirin codeine local anesthetic other_____
tetracycline latex fluoride

Patient signature (Parent of child) _____ Date_____

Dental Questionnaire

HOW ANXIOUS DO YOU BECOME **SCALE 0-5; 0-not at all, 5-very anxious)**

1. By the thought of the dental appointment before the actual visit. 0 1 2 3 4 5
2. Sitting in the dental chair during treatment. 0 1 2 3 4 5
3. When you hear the sound of the drill. 0 1 2 3 4 5
4. When receiving anesthesia/novocaine. 0 1 2 3 4 5
5. At the sight of dental instruments. 0 1 2 3 4 5
6. When not informed by your dentist on what has to be done. 0 1 2 3 4 5

DENTAL PROFILE

1. Are any of your teeth sensitive to cold, hot or sweets? Yes No
2. Are you satisfied with the appearance of your smile? Yes No
3. Do you wish your teeth were whiter? Yes No

A. Lichelle Aldana, DDS, PC

FAMILY DENTISTRY

9-B COLBY STREET • SALEM, MASSACHUSETTS 01970
(978) 745-9085

Warning Signs of Periodontal Disease

Don't Wait Until It Hurts. Let Us Help.

Periodontal disease is painless. It affects 75% of the population, and often, victims are unaware.

1. Gums that bleed when you brush your teeth?	Yes	No
2. Gums are red, swollen or tender?	Yes	No
3. Gums have pulled away (receded) from teeth?	Yes	No
4. Pus between teeth and gums when gums are pressed?	Yes	No
5. Permanent teeth are loose or separating?	Yes	No
6. Change in the way your teeth fit when biting?	Yes	No
7. Any change in fit of partial denture?	Yes	No
8. Persistent bad breath?	Yes	No

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