Rehoboth Beach Dental

19643 Blue Bird Lane, Unit 1
Rehoboth Beach, DE 19971
(302) 226-7960

PATENT HEALTH RECORD

There could be an important interrelationship with the dentistry you will receive and any health problems or medications. Thank you for answering the following questions.

Your Name:				**Date of Birth:**	
Address:					
City:			**State:**	**Zip Code:**	
Home Phone:		**Work Phone:**		**Cell Phone:**	
Social Security #:			**Driver's License #**		
Email Address:					
Sex:		**Weight:**		**Height:**	
☐ **Single**	☐ **Married**	☐ **Widowed**	☐ **Separated**	☐ **Divorced**	☐ **Domestic Partner**
Employer (Parent, if a minor):			**Occupation:**		
Spouse Name:		**Employer:**		**Phone:**	
Closest Relative:		**Relationship:**		**Phone:**	
Whom may we thank for referring you?					

MEDICAL HEALTH		
Physician:	**Address:**	**Phone:**
Have you been under the care of a physician in the past two years?	☐ **YES**	☐ **NO**
If "YES," for what reason?		
Have you been hospitalized or had a major operation? **If "YES," for what?**	☐ **YES**	☐ **NO**

MEDICATIONS: Please provide a ***current*** list or write them in the space provided • Please include bone density medications/injections such as **Fosamax** or **Prolia** and any **blood thinners**	**MEDICATIONS LIST (additional space can be found on the last page)**

WOMEN: Are you...	☐ Pregnant/Trying to get pregnant?	☐ Nursing?	☐ Taking oral contraceptives?

DO YOU HAVE, OR HAVE YOU HAD AND OF THE FOLLOWING? (Please check any that pertain)		
☐ Allergies (Seasonal)	☐ Epilepsy (seizures)	☐ Prolonged Bleeding
☐ Anemia	☐ Fainting	☐ Psychiatric Treatment
☐ Arthritis	☐ HIV+/AIDS	☐ Radiation Therapy (head/neck)
☐ Asthma	☐ Glaucoma	☐ Rheumatic Fever
☐ Cancer	☐ GERD/Acid Reflux	☐ Sinus Trouble/Infections
☐ Chemotherapy	☐ Hepatitis (B or C)	☐ Stroke
☐ High Cholesterol	☐ Kidney Disease	☐ Thyroid Disease
☐ Cold Sores	☐ Liver Disease	☐ Tuberculosis
☐ Diabetes	☐ Organ Transplant	☐ Ulcers

JOINT REPLACEMENT			
☐ Hip	☐ Knee	☐ Shoulder	☐ Other
Date of most recent joint replacement:			

Medical Health continued

ALLERGIES				
DO YOU HAVE ANY ALLERGIES OR ADVERSE REACTIONS TO THE FOLLOWING?	☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
	☐ Metals	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetic
Please list any other drug allergies:				

HEART CONDITIONS			
☐ Angina (Chest Pain)	☐ Bacterial Endocarditis	☐ Defibrillator	☐ Heart Transplant
☐ Artificial Heart Valves	☐ By-pass surgery	☐ Heart Attack/Disease	☐ Pacemaker
☐ A-Fib	☐ Congestive Heart Failure	☐ Heart Murmur	☐ Stent

BLOOD CIRCULATION ISSUES		
☐ History of Stroke	☐ High Blood Pressure	☐ Low Blood Pressure
Any other illness or disease not listed:		

TOBACCO USE		
Do you smoke?	☐ YES	☐ NO
Do you chew tobacco?	☐ YES	☐ NO
If you use tobacco products are you interested in quitting?	☐ YES	☐ NO

DENTAL HEALTH

When was your last dental visit?				
How often do you see your dentist?				
Are you having any dental issues that require immediate attention?				
Do you have any tooth sensitivity to the following:	☐ Hot	☐ Cold	☐ Chewing	☐ Sweets
How often do you brush your teeth?	Floss?		Waterjet?	
Do your gums bleed when brushing or flossing?	☐ YES		☐ NO	
Have you ever had periodontal (gum) treatment or "deep cleanings"?	☐ YES		☐ NO	
Do you clench or grind your teeth?	☐ YES		☐ NO	
Do your jaws ever feel tired or ache?	☐ YES		☐ NO	
Does your jaw click or pop?	☐ YES		☐ NO	
Do you have frequent headaches?	☐ YES		☐ NO	
Do you tend to lose or break fillings?	☐ YES		☐ NO	
Do you tend to crack or break teeth?	☐ YES		☐ NO	
Have you noticed any loose teeth?	☐ YES		☐ NO	
Have you noticed any excessive wear of your teeth?	☐ YES		☐ NO	
Do you have any food traps between teeth?	☐ YES		☐ NO	
Do you have a dry mouth or dry eyes?	☐ YES		☐ NO	
Are you missing any teeth?	☐ YES		☐ NO	
Have any missing teeth been replaced?	☐ YES		☐ NO	
How were they replaced?	☐ Fixed Bridge	☐ Implants	☐ Partial Denture	☐ Full Denture
Are you comfortable with how they were replaced?	☐ YES		☐ NO	
If not, please explain:				

Dental Health continued

How do you feel about your smile?		
Have you ever had cosmetic dentistry done to improve your appearance?	☐ YES	☐ NO
If so, are you pleased with the results?	☐ YES	☐ NO
Have you ever had an unpleasant dental experience?	☐ YES	☐ NO
If so, please explain:		

PLEASE READ CAREFULLY:

- To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.
- I also understand that I am financially responsible for all cost involved in my treatment. I authorize the attending dentist and his staff to render treatment
- I understand that Rehoboth Beach Dental is HIPAA compliant and I can request a copy of the standard HIPAA notices

Patient Signature:	**Date:**

MEDICATION LIST