Dehnert Dental

Chart #:_______________
FOR OFFICE USE ONLY

Patient Name:____ Date:____________________

Date of Last Dental Visit:______________________ Reason for this visit: ________________________________

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____

Have you ever had any history of Temporal Mandibular Joint Disease? [ ] No [ ]Yes
Have you ever had any discomfort in your Temporal Mandibular Joint? [ ] No [ ] Yes
Are you now or have you ever been, a smoker? No Yes If so how much?________________ How long?______________

Health Information

Please check those that apply:

Have you ever had any of the following?

[ ] AIDS/HIV
[ ] Latex Allergy
[ ] Allergies
[ ] Abnormal bleeding
[ ] Arthritis
[ ] Artificial Joints
[ ] Asthma
[ ] Blood Disease
[ ] Cancer
[ ] Diabetes
[ ] Dizziness/Fainting

[ ] Epilepsy
[ ] Excessive Bleeding
[ ] Glaucoma
[ ] Hay Fever
[ ] Head Injuries
[ ] Heart Disease/Problems
[ ] Heart Murmur
[ ] Hepatitis
[ ] High Blood Pressure
[ ] Jaundice
[ ] Kidney Disease
[ ] Liver Disease

[ ] Nervous Disorders
[ ] Mental Disorders
[ ] Pregnancy
Due date: _______
[ ] Radiation Treatment
[ ] Respiratory Problems
[ ] Rheumatic Fever
[ ] Rheumatism
[ ] Sinus Problems
[ ] Stomach Problems
[ ] Stroke
[ ] Tuberculosis

[ ] Tumors
[ ] Taken Fen-phen/ Redux
[ ] Ulcers
[ ] Venereal Disease
OTHER:
[ ]____________________
[ ]____________________

. Have you ever had any complications following dental treatment? Yes No
If yes, please explain:____

. Have you been admitted to a hospital or had surgical treatment for any condition? Yes No
If yes, please explain:____

. Are you now under the care of a physician? Yes No
If yes, please explain:____

. Name of Physician:_______________________________________ Phone ___________________________

. Do you have any health problems that need further clarification? Yes No
If yes, please explain: ____

. Are you taking any medications either over the counter or prescribed? Yes No
If yes, please list: ____

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. Are you allergic to any medications? Yes No If yes, please list: ________________________________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____Date:________________________
Signature of patient, parent or guardian

____Date:________________________
Signature of the dentist

Vital Signs: Blood pressure ______________ Date ________________ Time ______________

______________ ________________ ______________

______________ ________________ ______________