RF | RICHARDS FRANKEL DENTISTRY

Dentistry designed for health and well being.

PATIENT INFORMATION

1. Date _____
2. Full Name Mr., Ms., Mrs., Miss, Dr. _____

   _____
3. Date of Birth _____
4. Social Security Number _____
5. HIC/Patient ID Number _____
6. Marital Status (Please circle) Single // Married // Divorced // Widowed
7. Address _____
   - City _____
   - State _____
   - Zip _____
8. Home Phone _____
9. Cell Phone _____
10. Email Address _____
11. Employed by _____
12. Occupation _____
13. Business Address _____
    - City _____
    - State _____
    - Zip _____
14. Business Phone _____
15. Do you have dental insurance coverage _____ Ⓨ Ⓝ
    - Name of insured _____
    - Date of birth _____
    - Social security number _____
    - Name of carrier _____
    - Group number _____
    - Address _____
    - Phone number _____
16. Previous Family Dentist's Name _____
17. Physician's Name _____
18. Physician's Phone Number: _____
19. How did you hear about us? _____

    _____

PATIENT HEALTH HISTORY

Please answer the following accurately and completely. The diagnosis and treatment of your condition depends on the identification of every possible contributing factor. Although some of the questions may seem unrelated to your dental condition, they are all associated with proper management of your oral health.

20. Are you in good health _____ Ⓨ Ⓝ
21. Has there recently been any changes to your health _____ Ⓨ Ⓝ
22. Have you gained or lost weight in recent months _____ Ⓨ Ⓝ
    - If so, how much _____
23. Have you had any serious illnesses or operations _____ Ⓨ Ⓝ
    - If so, please explain _____

      _____
24. Are you currently under the care of a physician _____ Ⓨ Ⓝ
    - If so, for what _____
25. Date of last physical exam _____

    _____
26. Physician's name _____
27. Are you presently taking any drugs or medications _____ Ⓨ Ⓝ
    - If so, please list _____

      _____
28. Are you taking or have you ever taken bisphosphonate medications _____ Ⓨ Ⓝ
29. Do you currently have or previously had any of the following conditions
    - Heart Disease _____ Ⓨ Ⓝ
    - Rheumatic Fever _____ Ⓨ Ⓝ
    - High Blood Pressure _____ Ⓨ Ⓝ
    - Stroke _____ Ⓨ Ⓝ
    - Congenital Heart Disease _____ Ⓨ Ⓝ
    - Anemia & Blood Disorders _____ Ⓨ Ⓝ
    - Heart murmur _____ Ⓨ Ⓝ

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30. Do you have any medication allergies (e.g. Lidocaine, penicillin or other antibiotics, pain medications.) If yes, please list and describe your reaction _____

31. Do you have any of the below conditions
    - Nervous Disorders _____ Ⓨ Ⓝ
    - Ulcers _____ Ⓨ Ⓝ
    - Epilepsy _____ Ⓨ Ⓝ
    - Fainting Spells _____ Ⓨ Ⓝ
    - Asthma/Hay Fever _____ Ⓨ Ⓝ
    - Sinus Trouble _____ Ⓨ Ⓝ
    - Arthritis _____ Ⓨ Ⓝ
    - Glaucoma _____ Ⓨ Ⓝ
    - Diabetes _____ Ⓨ Ⓝ
    - Hepatitis _____ Ⓨ Ⓝ
    - Jaundice or Liver Disease _____ Ⓨ Ⓝ
    - Tuberculosis or Lung Disease _____ Ⓨ Ⓝ
    - AIDS or HIV _____ Ⓨ Ⓝ
    - Thyroid Condition _____ Ⓨ Ⓝ
    - Sexually Transmitted Disease _____ Ⓨ Ⓝ
    - Mitral Valve Prolapse _____ Ⓨ Ⓝ
    - Thyroid Disorders _____ Ⓨ Ⓝ
    - Have you ever been diagnosed with cancer _____ Ⓨ Ⓝ
        - If so, what type _____

32. Have you ever had radiation treatment _____ Ⓨ Ⓝ
33. Do you have frequent headaches _____ Ⓨ Ⓝ
34. Do you have chronic sores of any kind on your skin _____ Ⓨ Ⓝ
35. Do you get short of breath after one flight of stairs _____ Ⓨ Ⓝ
36. Do your ankles swell during the day _____ Ⓨ Ⓝ
37. Do you get pains in your chest or over your heart _____ Ⓨ Ⓝ
38. Have you been exposed to the HIV virus _____ Ⓨ Ⓝ
39. Do you have night sweats _____ Ⓨ Ⓝ
40. Have you ever used intravenous drugs _____ Ⓨ Ⓝ
41. Do you have swollen lymph nodes _____ Ⓨ Ⓝ
42. Have you ever had a blood transfusion _____ Ⓨ Ⓝ
43. Do you smoke _____ Ⓨ Ⓝ
    - If yes, how many packs per day _____
44. Do you drink alcohol _____ Ⓨ Ⓝ
    - If yes, how much _____

PATIENT DENTAL HISTORY

45. Have you ever had abnormal bleeding following dental extractions, surgery or a cut _____ Ⓨ Ⓝ
46. Have you ever had a serious problem associated with previous dental treatment _____ Ⓨ Ⓝ
47. Are you having any discomfort or pain in your mouth _____ Ⓨ Ⓝ
    - If yes, where _____
48. Are your teeth sensitive to cold, hot, sweets or pressure _____ Ⓨ Ⓝ
49. Do you clench or grind your teeth _____ Ⓨ Ⓝ
50. Do your jaws ache when you awaken in the morning _____ Ⓨ Ⓝ
51. Have you noticed any loose or shifting teeth _____ Ⓨ Ⓝ
52. Do you feel that you chew satisfactorily _____ Ⓨ Ⓝ
53. When you chew, do you have cracking, popping, or pain ___ Ⓨ Ⓝ
54. Are you satisfied with the appearance of your teeth _____ Ⓨ Ⓝ
55. Have you had orthodontic therapy (braces) _____ Ⓨ Ⓝ
56. Do your gums bleed when you brush _____ Ⓨ Ⓝ
57. Have you noticed any odor or bad taste in your mouth _____ Ⓨ Ⓝ
58. Do you ever get cold sores _____ Ⓨ Ⓝ
59. Have you had prior periodontal therapy _____ Ⓨ Ⓝ
60. Do you wear any removable appliances _____ Ⓨ Ⓝ

WOMEN ONLY

61. Are you pregnant _____ Ⓨ Ⓝ
    - Are you nursing _____ Ⓨ Ⓝ
62. Are you taking birth control pills _____ Ⓨ Ⓝ
63. Have you reached menopause _____ Ⓨ Ⓝ
64. Are you undergoing hormone therapy _____ Ⓨ Ⓝ

SIGNATURE

Patient's Signature_____

Date_____