Minden Dental Clinic
PATIENT HEALTH RECORD

Patient's Name:

LAST | FIRST | M.I.

Address

City State Zip

Phone ( ) Work ( )

Cell ( ) Birth Date

Gender Male ☐ Female ☐

Social Security No.

Occupation

Spouse/Parent

Insurance

Address

City State Zip

Group No.

Policy No.

Employee Name On Insurance Card

Employee Date of Birth

Social Security No.

Occupation

DENTAL HISTORY

YES ☐ NO ☐ Are you having any discomfort at this time? Where?

How long has it been since you have seen a dentist?

YES ☐ NO ☐ Are you anxious or nervous about dental treatment?

How often do you brush your teeth?

YES ☐ NO ☐ Are any of your teeth sensitive to the following? HOT ☐ COLD ☐ SWEET ☐ BITING ☐ CHEWING ☐

YES ☐ NO ☐ Do your gums feel tender or swollen or bleed when brushing your teeth?

YES ☐ NO ☐ Have you ever had pyorrhea or periodontal disease? (Gum disease)

YES ☐ NO ☐ Does food get caught between your teeth? Which areas?

YES ☐ NO ☐ Have you ever lost any teeth? Why were they lost?

YES ☐ NO ☐ Were you told they should be replaced?

How do you feel about your teeth?

If you could change anything about your teeth, what would you change?

PARENT/PATIENT SIGNATURE X _____ **DATE X** _____

DATE	Doctor Notes