Today's Date_____

Adult Health History and Patient Information
Berthoud Family Dentistry
Carmen L Beckwith, DDS, PC

NAME_____ Prefer to be called_____ M or F Birth date___/___/___ Age ___

Home Address_____ City_____ Zip_____ Hm Phone_____

Mailing Address (if different than home address)_____

Work Phone_____ Cell Phone_____ e-mail address_____

Employer_____ Occupation_____ SS#_____

When and Where are the best times to reach you?_____

Whom can we thank for referring you?_____

Emergency Contact_____ Relationship_____

Address_____ Hm Phone_____ Wk Phone_____

Person responsible for account (if other than patient)_____

Billing Address_____ City_____ St____ Zip_____

Home Phone_____ Work Phone_____

Relationship to patient_____ Social Security #_____ Birth Date_____

Employer_____

Dental Information

How often do you see the dentist?_____ Date of last exam?_____

What type of toothbrush do you use?_____
Do your gums bleed while brushing/flossing? . . . . . Y N
Are your teeth sensitive to any hot, cold, sweet and/or sour foods/liquids?. . . . . Y N
Have you ever noticed your teeth loosening? . . . . . Y N
Have you ever had your teeth straightened (orthodontia)? . . . . . Y N
Do you clench or grind your teeth while awake or asleep?. . . . . Y N
Are you bothered by the appearance of your teeth? . . . . . Y N
Have you ever had an upsetting dental experience? . . . . . Y N
Is there anything about receiving dental treatment that bothers you?. . . . . Y N

Please explain any "Y" answers above _____

Health History continued on back » » »

Are you allergic to any of the following?

Penicillin. . . . . Y N
Latex. . . . . Y N
Nickel. . . . . Y N
Any other metal or plastic . . Y N
Other Allergies?_____

If any of your answers are "Y", what happens when you are exposed to the allergen?_____
_____

Medical Information

Did/Do you have:

Any health problems. . . . . Y N
Ever been hospitalized . . . . . Y N
Taking any medications . . . . . Y N
Please list_____
Abnormal delivery as infant. . . . Y N
Rheumatic fever. . . . . Y N
Heart murmur. . . . . Y N
Asthma or respiratory problems Y N
Prolonged bleeding or anemia . . Y N
Thyroid or hormone therapy . . . Y N
Recurrent or chronic illness. . . . Y N
Organ transplants, joint replacement, Or ongoing health problems. . . Y N
High Blood Pressure or Heart Disease Y N

Physician:_____

Pregnant/nursing. . . . . Y N
Severe headaches . . . . . Y N
Pain of head/face. . . . . Y N
Diabetes. . . . . Y N
Psychiatric counseling. . . . . Y N
Blood Transfusions. . . . . Y N
Hepatitis . . . . . Y N
AIDS/HIV virus . . . . . Y N
Mouth/lip lesions (sores). . . . Y N
Other infections. . . . . Y N
Epilepsy/seizures. . . . . Y N
Chemotherapy or radiation treatment . . . . . Y N
Wear a hearing aid . . . . . Y N

Please explain any "Y" answers above_____
_____

Are you required to pre-medicate before receiving dental treatment due to any of the above? Y N

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

_____
Patient Signature Date

Office Use Only

Reviewed HH with pt
Date_____ initial _____
Date_____ initial _____
Date_____ initial _____
Date_____ initial _____
Date_____ initial _____
Date_____ initial _____
Date_____ initial _____
Date_____ initial _____
Date_____ initial _____

Premed's taken (if required)
date_____ time reported by pt_____ initial_____
date_____ time reported by pt_____ initial_____
date_____ time reported by pt_____ initial_____
date_____ time reported by pt_____ initial_____
date_____ time reported by pt_____ initial_____
date_____ time reported by pt_____ initial_____
date_____ time reported by pt_____ initial_____
date_____ time reported by pt_____ initial_____
date_____ time reported by pt_____ initial_____

Any changes
_____
_____
_____
_____