NICOLE M. BERGER, D.D.S., P.A.
PATIENT HEALTH RECORD

Please Print

Date____ Soc.Sec. No.____

Name____
(LAST) (FIRST) (MIDDLE)
Name you wish to be called____

Home Address____
(STREET) (CITY) (STATE) (ZIP)
____

Home Phone______________________________Business Phone___________________________Cell Phone______________________
Date of Birth___________________________E-Mail Address____
Sex________Height__________Weight____________Single________Married_________Widow_________Divorced________________
Occupation_________________________________Place of Employment____
Spouse's Name___________________________Date Of Birth_________________________Business Phone_______________________
Spouse Occupation_________________________________Place of Employment____
Dental Insurance Company____Policy Number______________________________
Closest Relative____Phone___________________________________
Who Recommended Our Office?___________________________________Most Convenient Time for Appointment________________
Person Responsible For Account__________________________________Driver's License#_____________________________________

MEDICAL HEALTH

Name and address of
Physician____
Are you taking any medications now? Yes No For What Purpose?____
List Medications_____________________________________ ____
_____________________________________ ____

Have you ever been treated for:

Heart Disease	Yes	No	Diabetes	Yes	No
Rheumatice Fever	Yes	No	Epilepsy	Yes	No
Abnormal Blood Pressure	Yes	No	Anemia	Yes	No
Heart Attack	Yes	No	Jaundice	Yes	No
Heart Valve Defect	Yes	No	Asthma	Yes	No
Heart Valve replacement	Yes	No	Sinus Trouble or Hay Fever	Yes	No
Heart Murmur	Yes	No	Cough	Yes	No
Hip Replacement	Yes	No	Hepatitis	Yes	No
Ulcers	Yes	No	AIDS/HIV	Yes	No
Tuberculosis	Yes	No	Arthritis	Yes	No
Nervous Disorders	Yes	No	Stroke	Yes	No
Lung Disease	Yes	No	Psychiatric Treatment	Yes	No
Venereal Disease	Yes	No	Cancer	Yes	No
Thyroid Disease	Yes	No	High Cholesterol	Yes	No

Are you Allergic to: Penicillin Codiene Local injected Anesthetics Other...
Have you received or are you currently receiving medication known as Bisphosphonates..Yes No
(for example zoledronic acid (Zometa) or Pamidronate Aredia)
Have you noticed any changes in your mouth or jaws?..Yes No
Have you noticed any foul smell, swelling or discharge in your mouth?...Yes No
Have you ever had radiation treatment?...Yes No
Are you subject to prolonged bleeding?...Yes No
Do you have trouble sleeping?..Yes No
Do you have problems with Digestion?..Yes No
Do you smoke?...Yes No How Much?____
Have you had any serious operations in the last 5 years?...Yes No
Are you subject to fainting spells?...Yes No
Do you have excessive urination and/or thirst?...Yes No
Have you ever been told to take antibiotics before dental treatment?..Yes No

(Women Only)

Are you pregnant?..Yes No How long?___________________________________

Do you have any problems associated with your menstrual period?..Yes No

Do you have a poor appetite?... .Yes No

DENTAL HEALTH

Reason for visit?____

When was your last dental visit?____

Name and Address of previous dentist____

____

Have you ever had any serious trouble associated with previous dental treatment?...Yes No

If so, explain____

____

Do you have periodic dental checkups?...Yes No

When did you last have your teeth professionally cleaned?____

How often do you brush your teeth?____

What texture brush do you use? **SOFT** **MEDIUM** **HARD** **NYLON** **NATURAL**

How often do you floss?____

Do your gums bleed when brushing?..Yes No

Do your gums bleed when flossing?..Yes No

Do you avoid brushing any part of your mouth because of pain?..Yes No

if yes, what part?____

Do you feel twinges of pain when your teeth come in contact with: Hot Cold Sweets Sours

Do your gums feel tender or swollen?..Yes No

Do you usually have many cavities?..Yes No

Do you lose fillings or break fillings?..Yes No

Are you usually nervous during dental visits?..Yes No

Do you prefer local anesthetic during dental visits?..Yes No

Do you gag easily?.. Yes No

Do you think you eat well-balanced meals?...Yes No

How do you feel about the general condition of your teeth and gums?..Yes No

____

Are you familiar with the term "preventative dentistry"?..Yes No

Do you have difficulty or pain, or both, when opening your mouth, as for instance, when yawning?..Yes No

Does your jaw get "stuck", "locked", or "go out"?...Yes No

Are you aware of noises in the jaw joints?...Yes No

Do you have pain in or about the ears, temples or cheeks?..Yes No

Does your bite feel uncomfortable or unusual?..Yes No

Do you have frequent headaches?...Yes No

If yes, how often?____

Have you had a recent injury to your head, neck or jaw? (Automobile accident)..Yes No

Have you previously been treated for a jaw joint problem (TMJ)?..Yes No

If so, when?____

Do you have any muscle or joint problems?..Yes No

Please add anything you feel is important____

____

Patient Signature:______________________________ **Dentist Signature:______________________________**

Date:_________________________ **Date:___________________________**