Mainely Teeth (207) 808-9498

admin@mainelyteeth.com

Health History

Please fill in the following information. Your answers are for our records only and will be kept strictly confidential subject to applicable laws. Please note that you will be asked some questions concerning your health. This information is vital to allow us to provide you the best care possible.

General Information

First name - Patient
First name:

Middle name
-

Last name - Patient
Last name:

Patient date of birth
-

Gender
Other

Email address
-

Contact Information

Home #
-

Work #
-

Mobile #
-

Patient mailing address
, ME, US
-

Patient billing address
, ME, US
-

Emergency Information

Emergency contact
-

Emergency #
-

Family doctor
-

☐ Has the main contact for the family, (usually a parent or guardian) changed since your last visit?
-

Family doctor #
-

☐ Has the main person responsible for payments for the family, (usually a parent or guardian) changed since your last visit?
-

Other Information

- [ ] Has your insurance information changed since your last visit?

-

Dental Information

- [ ] Do your gums bleed when you brush or floss?
- [ ] Are your teeth sensitive to cold, hot, sweets, or pressure?
- [ ] Does food or floss catch between your teeth?
- [ ] Have you had any periodontal (gum) treatment?
- [ ] Have you ever had orthodontic (braces) treatment?
- [ ] Have you had any problems associated with previous dental treatment?
- [ ] Is your home water supply fluoridated?
- [ ] Do you drink bottled or filtered water?
- [ ] Are you currently experiencing dental pain or discomfort?
- [ ] Do you have earaches or neck pains?
- [ ] Do you have any clicking, popping or discomfort in your jaw?
- [ ] Do you grind your teeth?
- [ ] Do you have any sores or ulcers in your mouth?
- [ ] Do you wear partial dentures?
- [ ] Do you wear full dentures?
- [ ] Have you ever had a serious injury to your head, neck or mouth?

-

Medical Information

Allergies

- [ ] Acetaminophen/Tylenol®
- [ ] Acrylic
- [ ] Animals
- [ ] Aspirin
- [ ] Codeine
- [ ] Demerol
- [ ] Erythromycin
- [ ] Fluoride
- [ ] Food
- [ ] Hay fever/seasonal
- [ ] Ibuprofen/Motrin®/Advil®
- [ ] Iodine
- [ ] Latex
- [ ] Local anesthetic
- [ ] Metals
- [ ] Morphine
- [ ] Penicillin
- [ ] Sulfa
- [ ] Tetracycline
- [ ] Other

-

Reactions

-

Conditions

- [ ] Abnormal/excessive bleeding
- [ ] AIDS or HIV infection
- [ ] Alzheimer's/dementia
- [ ] Anemia
- [ ] Angina
- [ ] Anxiety
- [ ] Arteriosclerosis
- [ ] Arthritis
- [ ] Asthma
- [ ] Autoimmune disease
- [ ] Back problems
- [ ] Blood disease
- [ ] Blood transfusion
- [ ] Breathing problems/ respiratory disease
- [ ] Bronchitis
- [ ] Cancer/chemotherapy/ radiation treatment
- [ ] Cardiovascular disease
- [ ] Chest pain upon exertion
- [ ] Chronic pain
- [ ] Congestive heart failure
- [ ] Damaged heart valves
- [ ] Diabetes
- [ ] Eating disorder
- [ ] Emphysema
- [ ] Epilepsy
- [ ] Fainting spells or seizures
- [ ] Frequent headaches
- [ ] Gastrointestinal disease
- [ ] G.E. Reflux/persistent heartburn
- [ ] Glaucoma
- [ ] Gout
- [ ] Hearing difficulties
- [ ] Heart attack
- [ ] Heart murmur
- [ ] Heart rhythm disorder
- [ ] Hemophilia
- [ ] Hepatitis, jaundice or liver disease
- [ ] High blood pressure
- [ ] Kidney problems
- [ ] Low blood pressure
- [ ] Low pain tolerance
- [ ] Malnutrition
- [ ] Mitral valve prolapse
- [ ] Neurological disorders
- [ ] Night sweats
- [ ] Osteoporosis/Paget's disease
- [ ] Other congenital heart defects
- [ ] Pacemaker
- [ ] Persistent swollen glands in neck
- [ ] Psychiatric care
- [ ] Recurrent Infections
- [ ] Rheumatic fever
- [ ] Rheumatic heart disease
- [ ] Rheumatoid arthritis
- [ ] Severe headaches/migraines
- [ ] Severe or rapid weight loss
- [ ] Sexually transmitted infection (STI)
- [ ] Sinus trouble
- [ ] Stroke
- [ ] Systemic lupus erythematosus
- [ ] Thyroid problems
- [ ] TMJ Disorder
- [ ] Tuberculosis
- [ ] Tumors or growths
- [ ] Ulcers
- [ ] Other

-

Details

-

Health History

Please indicate if you have or any of the following diseases or problems.

Preferred pharmacy

-

Pharmacy #

-

Date of last physical exam

-

☐ Do you have severe issues with coughing?

-

☐ Do you drink alcoholic beverages?

-

☐ Has there been any change to your general health within the past year?

-

☐ Have you had a serious illness, operation or been hospitalized in the past 5 years?

-

☐ Are you taking any prescription or over-the-counter medicines?

-

☐ Are you pregnant?

-

☐ Are you taking birth control or hormone replacement?

☐ Are you nursing?

☐ Have you ever reacted adversely to any medications or injections?

☐ Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?

-

☐ Do you use tobacco (smoking, snuff, chew, bidis)?

-

☐ Are you wearing a nicotine patch?

☐ Do you have sleep apnea?

Please list any surgical procedures you have undergone and when they occurred.

-

☐ Have you ever taken FosaMax®, Boniva®, Actonel® or other medications containing bisphosphonates?

☐ Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

-

Physician's phone number

-

Please read the above, and understand that the information provided in this form is accurate. A truthful health history will help ensure the best possible dental treatment. The information provided here will be used by the doctor and patient to inform any further discussion of the patient's health prior to or during an appointment. By signing below you also acknowledge that you will not hold the dentist, the dental practice or any other member of the practice staff responsible for any action or lack of action because of errors or omissions that may have been made during the completion of this form.