DAVID GOTEINER, DDS
practice limited to
periodontics and implantology
(908) 879-7709

Patient Health Record

In order to help me render the proper dental services to you, would you please be kind enough to answer the following questions. Please note the space for remarks for any answers that require clarification or any other information you think I should have. Thank you for your cooperation.

Name_____ Date of Birth_____

Address_____ Social Security No._____

Home Phone_____ Business Phone_____ My General Dentist is:_____

In case of emergency, whom should we contact?_____

Physician_____ Town_____ Phone _____ Last Physical Exam_____

Occupation_____ Job Title_____

Employer_____

Type of Dental Insurance (if applicable)_____ Social Security No. of Insured_____

Insured's Name_____ Group Number_____

Insured's Employer_____ Address_____ Phone_____

MEDICAL HEALTH

General Health (please circle): EXCELLENT GOOD FAIR POOR

Yes ☐ No ☐ Are you taking any medication now? What?_____
For what purpose?_____

Yes ☐ No ☐ Are you presently under a physician's care?_____

Yes ☐ No ☐ Have you ever had an operation, radiation or chemotherapy?_____

Yes ☐ No ☐ Have you ever been seriously ill?_____

Yes ☐ No ☐ Have you ever been hospitalized? Why?_____

Yes ☐ No ☐ Have you ever had Rheumatic heart disease or Rheumatic fever?_____

Yes ☐ No ☐ Have you ever been told by a physician that you have heart trouble, a murmur or mitral valve prolapse?_____

Yes ☐ No ☐ Have you ever been told by a physician that your blood pressure is high or low?_____

Yes ☐ No ☐ Do you have constant numbness or tingling in any part of your body?_____

Yes ☐ No ☐ Are any joints such as your ankles painful? Swollen?_____

Yes ☐ No ☐ Do you have arthritis?_____

Yes ☐ No ☐ Have you ever been treated for anemia (thin blood) or had a blood transfusion?_____

Yes ☐ No ☐ Do you have or has anyone in your family had diabetes? Who?_____

Yes ☐ No ☐ Have you ever had fainting spells, seizures or recurrent headaches?_____

Yes ☐ No ☐ Have you ever had liver trouble, hepatitis, or jaundice?_____

Yes ☐ No ☐ Have you ever been treated for kidney or bladder trouble?_____

Yes ☐ No ☐ Are you sensitive to or have you had any unusual reaction to any medicine, such as aspirin, penicillin, novocaine, sulfa, local injected anesthetics or others?_____

Yes ☐ No ☐ Do you have any allergies and if so to what?_____

Yes ☐ No ☐ Have you ever had hives or any skin rash?_____

Yes ☐ No ☐ Do you have either hay fever, asthma or sinus problems?_____

Yes ☐ No ☐ Have you ever been treated for a skin disease and if so what and when?_____

Yes ☐ No ☐ Have you ever been treated for stomach ulcers or stomach trouble?_____

Yes ☐ No ☐ Are you on any special type of diet and if so why? Has your weight changed recently?_____

Yes ☐ No ☐ Have you ever had excessive bleeding (for more than 24 hours) following a cut or dental extraction?_____

Yes ☐ No ☐ Do you bruise easily?_____

Yes ☐ No ☐ Do you have any tattoos?_____ Have you had electrolysis treatment?_____

Yes ☐ No ☐ Do you have AIDS, AIDS-related complex, or any other HIV-related infection?_____

Yes ☐ No ☐ Do you smoke? What?_____ How much?_____

Yes ☐ No ☐ Do you have any disease, condition or problem not listed? What?_____

FOR WOMEN ONLY

Yes ☐ No ☐ Is your menstrual cycle regular?_____

Yes ☐ No ☐ Have you reached menopause and if so do you have any symptoms?_____

How many pregnancies have you had?_____

How many children do you have?_____

If you are now pregnant state month_____and

Name of obstetrician_____

Yes ☐ No ☐ Do you anticipate becoming pregnant?_____

DENTAL HEALTH

Reason for this visit:_____Referred by:_____

Yes ☐ No ☐ Have you ever had any serious problem associated with previous dental treatment? If so, explain_____

Yes ☐ No ☐ Are you having dental pain?_____If so, how long have you noticed it?_____

Can you describe it as sharp_____dull_____constant_____intermittent_____

aggravated by hot_____ , cold_____, pressure on chewing_____

Yes ☐ No ☐ Do you frequently have canker sores, painful gums or a burning sensation in your mouth?_____

Yes ☐ No ☐ Do your gums ever bleed?_____If so, when?_____

When did you last have your teeth cleaned?_____

Where?_____

How frequently have you had your teeth cleaned in the last 10 years?_____

Yes ☐ No ☐ Do you have any teeth which seem to have become loose or have recently shifted position?_____

Yes ☐ No ☐ Have you noticed bad breath or bad taste from your mouth?_____

Yes ☐ No ☐ Have you ever had Vincent's Infection (Trench Mouth) and if so when?_____

Yes ☐ No ☐ Have you ever had gum boils and if so when?_____

Yes ☐ No ☐ Have you ever had periodontal treatment before? When?_____Who treated you?_____

Yes ☐ No ☐ Have you ever had orthodontic treatment? When?_____

Indicate approximately the date of your last tooth extraction_____

Yes ☐ No ☐ Did you need any medication before or after the extraction?_____

Yes ☐ No ☐ Was there any problem with bleeding, pain or healing after the extraction?_____

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

If yes, what part?_____

Do you feel twinges of pain when your teeth come in contact with:

Yes ☐ No ☐ a) hot foods or liquids, i.e., soup, coffee, tea, etc?_____

Yes ☐ No ☐ b) cold foods or liquids, i.e., ice cream, cold fruit, etc?_____

Yes ☐ No ☐ c) sweets, i.e., candy, fruit, sweet desserts, etc?_____

Yes ☐ No ☐ d) sours, i.e., lemons, limes, grapefruit, etc?_____

Yes ☐ No ☐ Does food tend to wedge between any of your teeth? Where?_____

Yes ☐ No ☐ Does your jaw ever click when you chew?_____

Yes ☐ No ☐ Do you ever have pain in your jaw or in the region in front of the ear?_____

Yes ☐ No ☐ Do you clench, grit or grind your teeth? If so, when?_____

Yes ☐ No ☐ Do you have any habits such as biting your nails, chewing on a pencil or pipe?_____

How often do you brush your teeth daily?_____

Please Circle: Do you routinely use dental floss, rubber tip, stimudents, water pik, electric toothbrush?

Yes ☐ No ☐ Are you presently dissatisfied with the appearance of your teeth?_____

Explain:_____

Yes ☐ No ☐ Are you worried about undertaking periodontal treatment?_____

Please add any additional information that you feel may be helpful or important in diagnosing and treating your condition.

_____

_____

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_____

(Patient) (Date)