Gallagher
Dentistry & Facial Pain Center

Welcome

PATIENT HEALTH HISTORY

We are delighted to have you join our office. Please take the time to complete this form.
It is important information that will help us provide you with the best possible care.

ABOUT YOU

Name: _____

I prefer to be called: _____ ❑ Female ❑ Male

Home Address: _____
Street

_____
City State Zip

Birth Date: ____/____/____ Social Security Number: _____

Marital Status: ❑ Single ❑ Married ❑ Other

Employer: _____ Present Occupation: _____

Business Address: _____
Street City State Zip

Name of Spouse: _____

Spouse's Employer: _____

Names of Dependents: _____

How do you enjoy spending your leisure time? _____

Who may we thank for referring you? _____

CONTACT INFORMATION

Home Phone: _____ Business Phone: _____

Email Address: _____ Cell Phone: _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Business Phone: _____ Cell Phone: _____

FOR PATIENTS WITH DENTAL INSURANCE

Primary Dental Insurance Policy:

Name of Insurance Company: _____

Insurance Claim Address: _____

_____

Group Number: _____

Policyholder's Name: _____

Policyholder SSN: _____

Policyholder Birth Date: _____

Secondary Dental Insurance Policy:

Name of Insurance Company: _____

Insurance Claim Address: _____

_____

Group Number: _____

Policyholder's Name: _____

Policyholder SSN: _____

Policyholder Birth Date: _____

DENTAL HISTORY

What led you to call our office for an appointment? _____

How would you describe the condition of your teeth? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Do you have any areas in your mouth that are sensitive or painful at times? ❑ Yes ❑ No

If yes, please explain: _____

_____

Do you have dental anxieties? If yes, what could we do to help? _____

_____

_____

If you could change anything about the appearance of your smile, what would you like to do?

_____

_____

Do you have an interest in whiter teeth? ❑ Yes ❑ No

When were you last seen by a dentist? _____

Name of previous dentist: _____ Did you have regular care? ❑ Yes ❑ No

As you come to a new dental practice, do you have specific expectations, concerns or priorities you would like us to know? _____

_____

_____

Have you had any particularly good or bad experiences with dentistry?

_____

_____

Have you had oral surgery? _____

Have you had orthodontic treatment? _____

Have you had root canal treatment? _____

Have you had cosmetic dentistry (ie; bonding, veneers)? _____

Are you missing any teeth? If so, how long have they been missing? _____

Do you wear a nightguard/splint for clenching or grinding your teeth? ❑ Yes ❑ No

PERIODONTAL SCREENING

How often do you brush your teeth? _____ How often do you floss? _____

Do you brush: ❑ Vigorously ❑ Moderately ❑ Gently

❑ Yes ❑ No Do you use rinses?

❑ Yes ❑ No Do your gums bleed when you brush?

❑ Yes ❑ No Have you ever had pocket measurements?

❑ Yes ❑ No A bone loss evaluation?

❑ Yes ❑ No Have you been treated for periodental disease?

❑ Yes ❑ No Root planing?

❑ Yes ❑ No Periodontal Surgery?

❑ Yes ❑ No Do you suspect that you have halitosis (bad breath)?

❑ Yes ❑ No Have you noticed loosening or mobility of your teeth?

❑ Yes ❑ No Do you suffer from pain and/or swelling of your gums?

❑ Yes ❑ No Do you clench your teeth during the day?

❑ Yes ❑ No Do you bite your lip or cheek regularly?

❑ Yes ❑ No Do you smoke cigarettes, cigars, or a pipe?

❑ Yes ❑ No Do you chew tobacco?

❑ Yes ❑ No Do you hold objects with your teeth, such as pencils, etc.?

❑ Yes ❑ No Do you grind your teeth at night?

❑ Yes ❑ No Do you sleep with your mouth open?

❑ Yes ❑ No Do you consume alcohol daily?

JAW/TMJ

❑ Yes ❑ No Have you been treated for TMJ?

❑ Yes ❑ No Have you ever experienced popping or clicking in your jaw?

❑ Yes ❑ No Chronic neck or shoulder pain?

❑ Yes ❑ No Difficulty chewing?

❑ Yes ❑ No Jaw pain?

❑ Yes ❑ No Locking?

❑ Yes ❑ No Chronic headaches? How often? _____

HEALTH HISTORY

Name of Personal Physician: _____

Address: _____ Phone: _____

Approximate date of last visit: _____ Current health condition: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Have you had serious health problems in the last five years? ❑ Yes ❑ No

If yes, please explain: _____

_____

Are you currently pregnant? ❑ Yes ❑ No If yes, how many months? _____

Do you take one or more vitamin supplements? If yes, please list: _____

Are you allergic to any medications such as penicillin, sulfa drugs, aspirin, etc.? ❑ Yes ❑ No

If yes, please list: _____

Are you currently taking: A beta-blocker (ie; Inderal, Corgard)? ❑ Yes ❑ No

A monomine oxidase inhibitor (MAOI) (ie; Nardil)? ❑ Yes ❑ No Any prescription medications? ❑ Yes ❑ No

The following conditions may require a pre-medication. Please check any that apply to you now or have in the past:

❑ Heart murmur ❑ Mitro valve prolapse ❑ Artificial valves
❑ Prosthetic implant ❑ Surgery with pins ❑ Rheumatic fever

Please indicate if you have had or been treated for any of the following diseases or medical problems:

❑ Abnormal bleeding
❑ Diabetes
❑ Epilepsy
❑ Cancer/Type _____
❑ Tuberculosis
❑ Transplant surgery
❑ Hepatitis A
❑ Bruise easily
❑ Drug/alcohol abuse
❑ Blood transfusion
❑ Blood relatives with diabetes
❑ Arthritis
❑ Radiation therapy
❑ Seizures
❑ Heart attack/stroke
❑ Hepatitis B
❑ Asthma
❑ Herpes
❑ Emphysema
❑ AIDS/HIV
❑ Ulcers
❑ Fainting spells
❑ Glaucoma
❑ Heart disease
❑ Hepatitis C
❑ Tumor
❑ Pacemaker
❑ Abnormal blood pressure
❑ Excessive urination
❑ Kidney trouble
❑ Depression
❑ Anemia
❑ Hay fever
❑ Nervous disorder
❑ Psychiatric condition
❑ Jaundice
❑ Auto immune/Lupus

When a health care worker is exposed to my blood or body fluids through a needle stick, cut or splash to the eye or mouth, I agree to have my blood tested for blood-borne diseases to include Hepatitis B and C and Human Immunodeficiency Virus (AIDS). *Please initial:* _____

Please list all medications and purpose of each:

Drug:	Dose:	Reason:

Signature: _____ Date: _____

Medical Update: Note changes, date and sign.

Date: _____ ❑ No change
B.P. _____
Notes: _____

Date: _____ ❑ No change
B.P. _____
Notes: _____

Date: _____ ❑ No change
B.P. _____
Notes: _____

Date: _____ ❑ No change
B.P. _____
Notes: _____