SpringRockDental

Adult Patient Health Form

Date: _____

Patient Name: _____ Date of Birth: _____

Medicaid #: _____ KP MRN: _____ Guardian (if applicable): _____

Patient Dental History (for age 19 and above)

Why are you visiting our office today? ☐ Exam ☐ X-rays ☐ Cleaning ☐ Other: _____

Approximate Date of Last Dental Visit: _____ Dentist Name: _____

Approximate Date of Last Dental X-rays: _____ Dentist Phone #: _____

Do you currently have any dental problems/pain that you are aware of or have you ever had any major dental problems in the past?	☐ Yes. Explain: _____ ☐ No
Do you have or get sores/ulcers in/around your mouth?	☐ Yes. Explain: _____ ☐ No
Have you had a serious injury to your mouth/head?	☐ Yes. Explain: _____ ☐ No
Do you have past dental problems or fears with dental treatment?	☐ Yes. Explain: _____ ☐ No
Do your gums bleed when brushing or flossing?	☐ Yes ☐ No
Do you have teeth that are sensitive to:	☐ Hot ☐ Cold ☐ Chewing ☐ Sugar
Do you have dry mouth problems?	☐ Yes ☐ No
Have you had gum treatments like deep cleaning or surgery?	☐ Yes ☐ No
Have you had braces or other orthodontic treatment?	☐ Yes ☐ No When: _____
Do you have a pop, clicking or cracking noise in your jaw?	☐ Yes ☐ No
Do you have pain in or near your ear?	☐ Yes ☐ No
Do you wear a night guard?	☐ Yes ☐ No
Do you grind, grit, or clench your teeth (while awake or asleep)?	☐ Yes ☐ No
Do you use:	☐ Mouthwash ☐ Fluoride mouthwash
Do you have the following:	☐ Migraines ☐ Headaches ☐ Noises in ears
Are you allergic to dental anesthetic?	☐ Yes ☐ No

Family Dental History

Do any dental problems run in your family?	☐ Yes. Explain: _____ ☐ No
Please rank the following family members' decay history, based on past or present cavities:	Mother: ☐ Many ☐ Few ☐ None Father: ☐ Many ☐ Few ☐ None Siblings: ☐ Many ☐ Few ☐ None

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Cavity Prevention History

Do you receive fluoride daily?	☐ Yes (water) ☐ Yes (supplement) ☐ No
Do you use a toothpaste containing fluoride?	☐ Yes ☐ No
How often do you brush your teeth every day?	☐ 1 ☐ 2 ☐ 3+
What type of toothbrush do you use?	☐ Manual ☐ Electric ☐ Battery
How often do you floss?	☐ Daily ☐ Occasionally ☐ Never
What do you use to floss?	☐ Floss ☐ Flosspicks ☐ Waterpik
How often do you drink soda, sports drinks, juice, coffee?	☐ Daily ☐ Once a week ☐ Other Explain:
Do you chew gum?	☐ Daily ☐ Weekly ☐ Occassionally
If you chew gum, how long do you chew it for?	☐ 20 minutes ☐ 30 minutes ☐ More
If you have children, do you know that you should help brush their teeth until they are 7 years old?	☐ Yes ☐ No

Medical History

If female, are you currently pregnant? If yes, how far along?	☐ Yes ☐ No How far along?
Have you had an orthopedic total joint replacement? (hip, knee, etc.)	☐ Yes. When: ☐ No Complications?
Are you taking or scheduled to begin taking either of the following medications: alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?	☐ Yes. When began? ☐ No
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hyperkalemia, or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐ Yes. Explain: ☐ No
Do you use medical marijuana?	☐ Edibles ☐ Oil ☐ Cream ☐ Smoke ☐ Vapor ☐ Other
Are you currently in treatment for cancer?	☐ Yes. Cancer type: ☐ No Treatment:
Have you had, or do you currently have any of the following conditions?	Heart murmur: ☐ Yes ☐ No Last heard: Heart trouble or stroke: ☐ Yes ☐ No Explain: Diabetes ☐ Yes ☐ No Congenital heart disease (CHD)? ☐ Yes ☐ No High or Low blood pressure ☐ High ☐ Low ☐ Neither Hepatitis, jaundice, or liver disease ☐ Yes ☐ No Epilepsy, convulsions, or fainting spells: ☐ Yes ☐ No Positive for HIV/AIDS virus ☐ Yes ☐ No Any serious illness not listed ☐ Yes ☐ No Explain:

Continued

Other History

Do you abuse alcohol or have controlled substance abuse?	☐ Yes ☐ No
Do you smoke cigarettes? If yes, how often?	☐ Yes ☐ No How often?
Do you use chewing tobacco? If yes, how often?	☐ Yes ☐ No How often?
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐ Yes ☐ No
Are you allergic to or have any medication reactions?	☐ Yes ☐ No Explain:
Please list your current medications:	

This is an annual form, and you will be asked to complete it each year.

I, _____, acknowledge that my child will receive an oral hygiene examination,
PRINT Name of Parent/Guardian
diagnosis treatment plan, and treatment from a registered dental hygienist (RDH) licensed in Colorado. I acknowledge that I will continue my oral hygiene maintenance in collaboration with a dentist and that a dentist should perform a dental examination twice yearly.

Patient/Parent/Guardian Signature: _____ **Date:** _____

RDH Signature: _____ **Date:** _____

Reviewed _____ Entered into Patient Chart _____ Scanned _____

OFFICE NOTES: REF CU PAIN ASAP OG REF DDS REF KP RXABX RXPAIN PREMED? KPPT NVSCRP4QFULL NVLTD SCRP PHOTOSNV PARMEDI PARDELTA PARCIGNA PAROTHER HIGHRISK-F-PAR SEALANTPAR CI C2 C3 C4 ?72/106