SALMON CREEK CENTER FOR
COMPLETE DENTISTRY

Excellence in Restorative Care

G. RUSSELL CHURCH, D.M.D.

PATIENT HEALTH RECORD

PATIENTS NAME ______ Date: ______

Soc. Sec. # ______ Birth date ______ Sex ______

WHOM MAY WE THANK FOR REFERRING YOU TO US? ______

GUARANTOR INFORMATION (Person Responsible For Account) (If Minor - Custodial Parent or Guardian)

Name ______ Soc. Sec. # ______ Birth date ______

Address ______ City ______ State ______ Zip ______

Home Phone ( ) ______ Cell Phone ( ) ______ Work Phone ( ) ______

E-mail Address ______ Alternate Contact Name ______

Address ______ City ______ State ______ Zip ______

Occupation ______ Employer ______

Spouses Name ______ Soc. Sec. # ______ Birth date ______

Spouses Occupation ______ Employer ______ Phone ( ) ______

INSURANCE INFORMATION Note: Please provide us with your benefit card(s)

1. Primary Subscriber Name ______ Birth date ______ Soc. Sec. # ______

   Employer ______ Insurance Company ______

2. Secondary Subscriber Name ______ Birth date ______ Soc. Sec. # ______

   Employer ______ Insurance Company ______

Release of Benefits and Information: I authorize my insurance benefits to be paid directly to the doctor. I am financially responsible for any balance due. I authorize the doctor or insurance company to release any information required for claims.

SIGNATURE ______ Date ______

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DENTAL HEALTH

What are your chief concerns?

When was your last dental visit? Previous Dentist:

Are you having any dental problems that require immediate attention?

Do any of the following cause tooth discomfort? ☐ Hot ☐ Cold ☐ Sweets ☐ Chewing

Have you ever had slow healing sores in or about your mouth? ☐ Yes ☐ No

Do your gums bleed while cleaning? ☐ Yes ☐ No

Do your gums ever feel tender or swollen? ☐ Yes ☐ No

Do you smoke tobacco? ☐ Yes ☐ No Chew tobacco? ☐ Yes ☐ No

Do you clench or grind your teeth? ☐ Yes ☐ No

Do your jaws ever feel tired or ache? ☐ Yes ☐ No Click or pop? ☐ Yes ☐ No

Can you chew on both sides of your mouth? ☐ Yes ☐ No Comfortably? ☐ Yes ☐ No

Do you have frequent headaches? ☐ Yes ☐ No Earaches? ☐ Yes ☐ No

Have you ever had orthodontic treatment (braces)? ☐ Yes ☐ No When?

Do you have any loose teeth? ☐ Yes ☐ No Cracked or broken teeth? ☐ Yes ☐ No

Do you have any noticeable wear on your teeth? ☐ Yes ☐ No Food traps between teeth? ☐ Yes ☐ No

Do you have any missing teeth? ☐ Yes ☐ No Have they been replaced? ☐ Yes ☐ No

If so, how? ☐ Fixed bridge ☐ Removable partial ☐ Full denture ☐ Dental implant

Are you comfortable with the replacement? Please describe

How do you feel about the appearance of your smile?

If you could, what would you change about your smile?

- Close gaps ☐ Yes ☐ No
- Replace missing teeth ☐ Yes ☐ No
- Straighten crooked teeth ☐ Yes ☐ No
- Fix worn teeth ☐ Yes ☐ No
- Fix chipped edges ☐ Yes ☐ No
- Adjust size ☐ Yes ☐ No
- Whiten teeth ☐ Yes ☐ No
- Other - What?

Have you ever had any cosmetic dentistry done to improve your appearance?

If yes, are you pleased with the result? ☐ Yes ☐ No Please comment

Have you ever had an unpleasant dental experience? ☐ Yes ☐ No Please comment

Please add anything you feel is important:

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MEDICAL HEALTH

PATIENTS NAME

Name and phone number of physician

Have you been under a physician's care during the past 2 years? For

Have you been treated in a hospital in the past 2 years? For

Have you ever had major surgery?

If female: Are you taking hormones or birth control? Are you pregnant or nursing?

Are you now taking or have you taken any prescription drugs during the past year? For

Are you allergic to ☐ Penicillin ☐ Codeine ☐ Latex ☐ Other

Date: BP: Medications:

HAVE YOU HAD OR DO YOU NOW HAVE:

	yes	no		yes	no		yes	no
Abnormal or high blood pressure	☐	☐	Glaucoma	☐	☐	Organ transplant	☐	☐
AIDS	☐	☐	Heart attack / Failure	☐	☐	Pacemaker	☐	☐
Allergies	☐	☐	Heart disease	☐	☐	Prolonged bleeding	☐	☐
Anemia	☐	☐	Heart murmur	☐	☐	Prolonged cough	☐	☐
Angina / Chest Pain	☐	☐	HIV	☐	☐	Psychiatric treatment	☐	☐
Arthritis	☐	☐	Hyper/Hypothyroid	☐	☐	Radiation therapy	☐	☐
Artificial joints	☐	☐	Hemophilia	☐	☐	Recovering alcoholic	☐	☐
Asthma	☐	☐	Hepatitis A	☐	☐	Rheumatic fever	☐	☐
Cancer	☐	☐	Hepatitis B, C or D	☐	☐	Sinus trouble	☐	☐
Chemotherapy	☐	☐	Herpes - Cold Sores	☐	☐	Substance Abuse	☐	☐
Diabetes	☐	☐	Jaundice	☐	☐	Stroke	☐	☐
Dialysis/Shunts	☐	☐	Kidney disease	☐	☐	Tuberculosis	☐	☐
Epilepsy	☐	☐	Liver disease	☐	☐	Ulcers	☐	☐
Fainting	☐	☐				Marijuana use in past 48 hrs.	☐	☐

Have you ever had any other serious illness not indicated above? ☐ Yes ☐ No Discuss

Do you wish to talk to the dentist privately about any problem? ☐ Yes ☐ No

CONSENT; I understand the above information is necessary to provide me with dental care in a safe and efficient manner. The information on this page and the medical history are correct to the best of my knowledge. I understand the use of anesthetic agents can embody a certain risk and I hereby authorize the Dental Office to administer such medication and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.

PATIENT SIGNATURE Date

OFFICE USE ONLY

Date: BP:

Physician & Phone

Medications & Condition Update:

Date: BP:

Physician & Phone

Medications & Condition Update:

Date: BP:

Physician & Phone

Medications & Condition Update:

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