PATIENT HEALTH HISTORY

Please Read

Will you kindly answer the following questions. In this office, we are very much interested in helping you with your program of health and well being. We feel that this interest in your appearance, comfort, and ability to chew, digest and enjoy your food is one of the reasons why you are here.

In order to prevent or control disease to maintain healthy teeth, gums and bone, it is necessary as a part of any complete examination, to know about your general health and feelings. This information is invaluable in determining accurate treatment suggestions, which will be discussed with you in detail. This information, of course, will be held confidential.

Referred To Office By _____

IF THIS APPOINTMENT IS FOR YOU START HERE

IF THIS APPOINTMENT IS FOR YOUR CHILD, START HERE

PLEASE PRINT **1**

Date _____
Name _____
Address _____
City _____ State _____ Zip _____
Home Phone # _____
Cell Phone # _____
Business Address _____
Business Phone # _____
Birthdate _____
Married____ Single____ Divorced____ Widowed____
Occupation _____
Email _____

Date _____
Name _____
Address _____
City _____ State _____ Zip _____
Home Phone # _____
Birthdate _____ Age _____ Grade _____
School _____

If your child's name and address are not the same as yours, please fill in the box on top also.

INSURANCE **2**

Primary Carrier
Insurance Co. _____
Employer _____
Union or Local # _____
Group # _____
Badge # _____
Date Employed _____
Social Security # _____

Secondary Carrier
Insurance Co. _____
Employer _____
Union or Local # _____
Group # _____
Badge # _____
Date Employed _____
Social Security # _____

JEFFREY P. GILLER, D.D.S.
PRACTICE LIMITED TO PERIODONTICS
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Franklin Square, NY 11010
(516) 565-2018

MEDICAL HISTORY:

1. GENERAL HEALTH (please check): EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐
2. NAME AND ADDRESS OF PHYSICIAN _____

(PHONE #)

3. LAST COMPLETE PHYSICAL? _____

	YES	NO
4. ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN?	☐	☐
IF YES, PLEASE EXPLAIN _____		
5. HAVE YOU BEEN HOSPITALIZED OR HAD A SERIOUS ILLNESS WITHIN THE LAST 5 YEARS?	☐	☐
IF YES, PLEASE EXPLAIN _____		
6. ARE YOU TAKING ANY MEDICATION NOW? (PILLS, VITAMINS, SYRUP, ETC.)	☐	☐
PLEASE LIST _____		

7. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING PROBLEMS OR DISEASES?

(CHECK BOX)	YES	NO		YES	NO
HEART DISEASE OR HEART ATTACK	☐	☐	JAUNDICE, HEPATITIS OR LIVER DISEASE	☐	☐
RHEUMATIC FEVER	☐	☐	ASTHMA OR HAY FEVER	☐	☐
HEART MURMUR	☐	☐	SINUS TROUBLE	☐	☐
ABNORMAL BLOOD PRESSURE	☐	☐	HIV POSITIVE	☐	☐
ULCERS	☐	☐	ARTHRITIS OR SORE JOINTS	☐	☐
TUBERCULOSIS OR LUNG DISEASE	☐	☐	STROKE	☐	☐
DIABETES OR ANEMIA	☐	☐	GLAUCOMA	☐	☐
CONGENITAL HEART LESIONS	☐	☐	VENEREAL DISEASE	☐	☐
OTHER _____	☐	☐	CANCER, TUMORS OR GROWTHS	☐	☐

	YES	NO
8. ARE YOU ALLERGIC TO ANY DRUGS OR MEDICATION SUCH AS PENICILLIN, CODEINE, ASPIRIN OR LOCAL INJECTED ANESTHETICS?	☐	☐
IF YES, WHAT? _____		
9. ARE YOU SUBJECT TO PROLONGED BLEEDING?	☐	☐
10. ARE YOU SUBJECT TO FAINTING SPELLS?	☐	☐
11. DO YOU HAVE EXCESSIVE URINATION AND/OR THIRST?	☐	☐
12. DO YOU USE TOBACCO?	☐	☐
IF YES, HOW MANY PACKS/DAY? _____		

WOMEN:

	YES	NO
1. ARE YOU PREGNANT?	☐	☐

DENTAL HISTORY:

	YES	NO
1. ARE YOU AWARE OF ANY DENTAL PROBLEMS AT THIS TIME?	☐	☐
IF YES, PLEASE EXPLAIN _____		
2. WHEN WAS YOUR LAST DENTAL VISIT? _____		
3. ARE YOU SEEN IN A DENTAL OFFICE ON A REGULAR BASIS?	☐	☐
4. WHEN WAS YOUR LAST FULL MOUTH SERIES OF X-RAYS TAKEN? _____		
5. WHEN WAS YOUR LAST DENTAL CLEANING? _____		
6. DO YOUR GUMS BLEED WHILE BRUSHING?	☐	☐
7. HAVE YOU EVER HAD INSTRUCTION IN ORAL HYGIENE TECHNIQUE?	☐	☐
8. HOW OFTEN DO YOU BRUSH YOUR TEETH?		
9. DO YOU USE ANY OF THE FOLLOWING?		
TOOTHBRUSH HARD ☐ MEDIUM ☐ SOFT ☐ FLOSS ☐ TOOTHPICKS ☐ OTHER _____		
10. DO YOU CHEW ON ONLY ONE SIDE OF YOUR MOUTH?	☐	☐
IF YES, EXPLAIN _____		
11. ARE YOU FAMILIAR WITH THE TERM, "PREVENTIVE DENTISTRY"?	☐	☐
12. ARE YOU PLEASED WITH THE APPEARANCE OF YOUR TEETH?	☐	☐
IF NOT, WHY? _____		
13. DOES THE NOISE OF HIGH SPEED EQUIPMENT BOTHER YOU?	☐	☐
14. INTERESTS AND HOBBIES _____		

TO THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEDING ANSWERS ARE TRUE AND CORRECT. IF I EVER HAVE ANY CHANGE IN MY HEALTH, OR IF MY MEDICINES CHANGE, I WILL INFORM THE DOCTOR OF DENTISTRY AT THE NEXT APPOINTMENT WITHOUT FAIL.

DATE

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN

SIGNATURE OF DENTIST