JOHNSON AND TRANG DENTAL P.C.

9321 Haggerty Rd., Plymouth, MI 48170 ● (734) 455-4070

PATIENT HEALTH RECORD

Date: _____

Name: _____ Phone: (C) _____
Address: _____ (H) _____
City: _____ State: _____ Zip: _____ (W) _____
Employed by: _____ Birthdate: _____
Position _____ Social Security #: _____
Address: _____ Dental Insurance: _____
Email: _____ Group Number: _____
ID #: _____

Spouse's Name: _____ Birthdate: _____
Employed by: _____ Social Security #: _____
Position: _____ Dental Insurance: _____
Work Phone: _____ Group Number: _____
Address: _____ ID #: _____
Email: _____

Name of a friend, neighbor or relative in case of emergency: _____
Address: _____ Phone: _____
Who will pay this account? (Whose name will appear on the billing statement?) _____

MEDICAL HISTORY

Physician's Name: _____ Date of last physical exam: _____
Are you taking any medication now? □ Yes □ No For what purpose: _____

Have you ever been treated for:

Heart Disease _____	□ Yes	□ No	Heart Murmur _____	□ Yes	□ No
Rheumatic Fever _____	□ Yes	□ No	Jaundice _____	□ Yes	□ No
Abnormal Blood Pressure _____	□ Yes	□ No	Asthma _____	□ Yes	□ No
Ulcers _____	□ Yes	□ No	Hay Fever _____	□ Yes	□ No
Tuberculosis or Lung Disease _____	□ Yes	□ No	Sinus Trouble _____	□ Yes	□ No
Diabetes _____	□ Yes	□ No	A.I.D.S./H.I.V. _____	□ Yes	□ No
Epilepsy _____	□ Yes	□ No	Hepatitis Type _____	□ Yes	□ No
Anemia _____	□ Yes	□ No	Arthritis _____	□ Yes	□ No
Congenital Heart Disease _____	□ Yes	□ No	Stroke _____	□ Yes	□ No
Prosthetic Joints _____	□ Yes	□ No	Heart Attack _____	□ Yes	□ No
Prosthetic Heart Valves _____	□ Yes	□ No	Glaucoma _____	□ Yes	□ No
Kidney Dialysis _____	□ Yes	□ No	Cancer _____	□ Yes	□ No

Allergies: Penicillin _____ Codeine _____ Local injected anesthetics _____ Other medications __ _____

Are you subject to proglonged bleeding? □ Yes □ No
(Women) Are you pregnant? □ Yes □ No How Long? _____

Parent's Signature: _____ Date: _____

How did you hear about our office? _____

What is the reason for the visit? _____

When was your last dental visit? _____

What was done at that visit? _____

When were your last bitewing (cavity detecting) X-rays taken? _____

When was your last full set of X-rays taken? _____

Have you ever had a bad experience in a dental office? _____

What type of toothbrush do you use? Soft Medium Hard Nylon Natural

Have you ever been treated by a dental specialist? _____

Give details: _____

_____

Do you have pain or clicking or grinding in your jaw joints? _____

Do you have trouble opening wide? _____ Yawning? _____

Do you favor one side when you chew? _____

Do you get frequent headaches or ear aches? _____

Do you grind your teeth at night? _____

Do you clench or rind when tense? _____

Does your jaw ever feel tired? _____

Have you ever been treated for any of these problems or for a bad bite? _____

_____

Are any of your teeth sensitive to: Sweet Cold Hot Chewing Brushing or Flossing

Do you get food caught between your teeth? _____

Do your gums bleed? _____

Do you get a bad taste from your gums or teeth? _____

Do you have any loose teeth? _____

Have you ever had gum treatments (Periodontal treatment or therapy)? _____

_____

Do you have any cracked or broken fillings or teeth? _____

Do you have any large fillings? _____

Are any teeth stained from repeated filling? _____

How do you feel about the appearance of your teeth? _____

What would you change about them? _____

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____