GENESIS DENTAL CENTER BAHAMAS LTD.

Your answers on this form will help your health care provider get an accurate history of your medical concerns and conditions. If you are a current patient, there is a shorter update form you can use. Please fill in all **six** pages. It is long because it is a GENESIS DENTAL CENTER. We really want to know you well so we can properly care for you. If you cannot remember specific details, please provide your best guess. If you are uncomfortable with any questions, do not answer them. Thank you!

Who referred you to my practice? Circle one: patient, family member, physician, assigned.

Patient's Full Name: _____
Attending Dentist's Full Name: _____
Patient ID#: _____
Date Submitted: _____

Dental History Form

Please complete both sides of this dental/medical history form so that we may provide you with the best possible dental care. All information is strictly confidential.

Reason for Today's Visit
What is the reason for your visit today?
Date of last dental visit: _____
Last dental cleaning date: _____
What was done during your last dental visit?

Previous dentist's name: _____
Previous dentist's address: _____
Contact number: _____

Dental Habits

How often do you have dental examinations? _____

How often do you brush your teeth? _____

How often do you floss? _____

Last full-mouth X-ray date: _____

Have you ever used or are you currently using topical fluoride?

☐ Yes ☐ No

What dental aids do you use (Interplak, toothpicks, etc.)?

Do you have any dental problems right now?

☐ Yes ☐ No

If yes, please describe:

_____

_____

Tooth Sensitivity

Are any of your teeth sensitive to:

Hot or cold? ☐ Yes ☐ No

Sweets? ☐ Yes ☐ No

Biting or chewing? ☐ Yes ☐ No

History of Dental Treatments

Have you ever had:

Orthodontic treatment? ☐ Yes ☐ No

Oral surgery? ☐ Yes ☐ No

Periodontal (gum) treatment? ☐ Yes ☐ No

Teeth ground or your bite adjusted? ☐ Yes ☐ No

A bite plate or mouth guard? ☐ Yes ☐ No

A serious injury to the mouth or head? ☐ Yes ☐ No

If yes, where? _____

Have your parents experienced gum disease or tooth loss?

☐ Yes ☐ No

Symptoms You May Have Experienced

Have you noticed any loose teeth or changes in your bite?

☐ Yes ☐ No

Do you experience:

Clicking or popping the jaw? ☐ Yes ☐ No
Pain in the jaw, ear, or side of the face? ☐ Yes ☐ No
Difficulty opening or closing your mouth? ☐ Yes ☐ No
Difficulty chewing on either side? ☐ Yes ☐ No
Headaches, neck aches, or shoulder aches? ☐ Yes ☐ No
Sore muscles (necks, shoulders)? ☐ Yes ☐ No

Does food frequently catch between your teeth?
☐ Yes ☐ No
If yes, where? _____

Personal Dental Habits

Do you:

Clench or grind your teeth (day or night)? ☐ Yes ☐ No
Bite your lips or cheeks regularly? ☐ Yes ☐ No
Hold objects with your teeth (pencils, pins, nails, etc.)? ☐ Yes ☐ No
Mouth breath (awake or asleep)? ☐ Yes ☐ No
Snore or have sleeping disorders? ☐ Yes ☐ No
Smoke or use tobacco products? ☐ Yes ☐ No

Are you satisfied with the appearance of your teeth?
☐ Yes ☐ No

Would you like to keep all your teeth for your entire life?
☐ Yes ☐ No

Have your jaws ever felt tired, especially in the morning?
☐ Yes ☐ No

Dental Anxiety & Past Experiences

Do you feel nervous about dental treatment?
☐ Yes ☐ No
If yes, what is your biggest concern?

Have you ever had an upsetting dental experience?

☐ Yes ☐ No

If yes, please describe:

Have you ever been advised to take medication before dental treatment?

☐ Yes ☐ No

Is there anything else about dental treatment that you would like us to know about?

☐ Yes ☐ No

If yes, please describe:

_____

_____

What are your health goals for the next year? **How would you rate your health? (circle one): Excellent / Good / Fair / Poor**

Please list healthcare providers & their specialty you see regularly:

List any medical suppliers you use (e.g. respiratory supplies, etc):

MEDICATIONS: *Please list (or show us your own printed record)* **all** *prescriptions and non-prescription medications. This includes vitamins, herbs, supplements, home remedies, birth control pills, inhalers, over the counter pain pills (Advil, Aleve, Tylenol, etc).*

- *Check box if you do not take any prescription or over the counter medications.*
- *Check box if you brought a list of your medications (give it to my assistant and don't write in medications below).*

Medication	*Dose (e.g. mg/pill)*	*How many times per day?*

Condition	Now	Past	Comments
Alcohol / Drug abuse			
Allergy (Hay Fever)			
Anemia			
Anxiety			
Arthritis (Rheumatoid)			
Arthritis (Osteoarthritis)			
Asthma			
Bladder / Kidney Problems			
Cancer Breast			
Cancer Colon			
Cancer Other Type			
Cancer Ovarian			
Cancer Prostate			
Cataracts			
Chicken Pox			
Colon Polyp			
Coronary Artery Disease			
Depression			
Diabetes (adult onset)			
Diabetes (childhood onset)			
Hepatitis – Other			
High Blood Pressure			
High Cholesterol			
Hip Fracture			
HIV/ AIDS			
Irritable Bowel Syndrome			
Kidney Disease / Failure			
Kidney Stones			

INSURANCE INFORMATION

Subscriber Name: _____ ZIP:_____

Date of Birth: _____ Subscriber ID Number: _____

Insurance Company: _____ **Insurer is:** ☐ Primary ☐ Secondary ☐CHILD

Address: _____ **Phone:**_____

Employer: _____ **Group Number:** _____