

Millennium Dental No1 LLP

125 Hamilton St • Bound Brook, NJ 08805
732-356-6665

Chart # _____

PATIENT HEALTH RECORD

To help us provide the proper dental care, please answer the following questions completely. Use the space provided for any answer that needs explanation or for any other information you think we should have. All information is kept confidential. Thank you for your cooperation.

Date _____

PATIENT INFORMATION

Last Name _____ First Name _____ Middle _____

Address _____ City _____ State _____ ZIP _____

Home/Cell Phone _____ Business Address _____ Work Phone _____

Date of Birth _____ Sex _____ Height _____ Weight _____ Occupation _____

Social Security No. _____ Referred By _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced Spouse's Name _____

Dental Insurance (if applicable) _____ Policy / ID # _____

Purpose of This Appointment _____ Best Appointment Time _____

DENTAL HISTORY

Are you here for emergency treatment? Yes ☐ No ☐ Are you in pain now? Yes ☐ No ☐

Date of Last Dental Visit _____ Date of Last Full-Mouth X-rays _____

Have you ever been a patient at a dental school? Yes ☐ No ☐ If yes, when? _____

MEDICAL HISTORY

General health (please check): ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Has your health declined in the past five years? Yes ☐ No ☐

List any hospitalizations or serious illnesses in the past five years, with dates:

Do you have a physician (M.D.)? Yes ☐ No ☐

Physician's Name _____ Phone _____

Physician's Address _____

Date of Last Complete Physical _____ Date of Last Medical/Chest X-rays _____

Are you taking any medication now? Yes ☐ No ☐ For what purpose? _____

List all medications, vitamins, and supplements you are currently taking:

Are you allergic to any of the following? ☐ Penicillin ☐ Codeine ☐ Local anesthetics (numbing)

☐ Other: _____

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PATIENT HEALTH RECORD

Last Name / First Name _____ Date of Birth _____

HAVE YOU EVER HAD OR BEEN TREATED FOR ANY OF THE FOLLOWING?

	Yes	No		Yes	No
1. Heart disease or heart attack	☐	☐	23. Kidney problems	☐	☐
2. Rheumatic fever / rheumatic heart disease	☐	☐	24. Kidney dialysis	☐	☐
3. Heart murmur or mitral valve prolapse	☐	☐	25. Hepatitis	☐	☐
4. Congenital heart defect	☐	☐	26. Jaundice	☐	☐
5. Artificial (prosthetic) heart valve	☐	☐	27. Liver disease	☐	☐
6. Angina (chest pain)	☐	☐	28. Stomach ulcers	☐	☐
7. Irregular heartbeat	☐	☐	29. Anemia	☐	☐
8. Pacemaker	☐	☐	30. Blood disorder, prolonged bleeding, or easy bruising	☐	☐
9. High or low blood pressure	☐	☐	31. Epilepsy, seizures, or convulsions	☐	☐
10. Stroke	☐	☐	32. Fainting spells	☐	☐
11. Short of breath with light exercise or lying down	☐	☐	33. Glaucoma	☐	☐
12. Swollen ankles	☐	☐	34. Arthritis or rheumatism	☐	☐
13. Asthma or hay fever	☐	☐	35. Artificial (prosthetic) joints	☐	☐
14. Emphysema or difficulty breathing	☐	☐	36. Lupus	☐	☐
15. Tuberculosis or other lung disease	☐	☐	37. Other autoimmune disease	☐	☐
16. Positive TB skin test (PPD)	☐	☐	38. Swollen lymph nodes or glands	☐	☐
17. Persistent cough or coughing up blood	☐	☐	39. HIV / AIDS	☐	☐
18. Sinus trouble	☐	☐	40. Sexually transmitted infection (syphilis, gonorrhea)	☐	☐
19. Diabetes	☐	☐	41. Pelvic disease	☐	☐
20. Recent increase in urination or thirst	☐	☐	42. Psychiatric treatment	☐	☐
21. Thyroid problems	☐	☐	43. Radiation therapy or chemotherapy	☐	☐
22. Unexplained weight loss in the past year	☐	☐	44. Other: _____		

WOMEN ONLY

Are you pregnant? Yes ☐ No ☐ If yes, how many weeks? _____

Are you taking birth control pills? Yes ☐ No ☐ Are you nursing? Yes ☐ No ☐

HAVE YOU EVER HAD ANY OF THE FOLLOWING ORAL CONDITIONS?

Dry mouth (xerostomia)	Yes ☐ No ☐	Bad breath (halitosis)	Yes ☐ No ☐
Burning in the mouth	Yes ☐ No ☐	Mouth rash or yeast infection (thrush)	Yes ☐ No ☐
Sores in the mouth	Yes ☐ No ☐	Chronic bleeding of the mouth or gums	Yes ☐ No ☐

REMARKS

Please explain any "Yes" answers above or add anything else we should know:

I certify that the information above is complete and accurate to the best of my knowledge. I will inform the office of any changes in my health or medications.

Signature of Patient (or Parent/Guardian if under 18)

Relationship to Patient

Date

OFFICE USE ONLY — Reviewed by: _____ Date: _____