# CONFIDENTIAL HEALTH HISTORY

Patient Name:_____ Date of Birth:_____

**I. CIRCLE APPROPRIATE ANSWER** (Leave blank if you do not understand the question)

1. Yes No Is your general health good?
   If NO, explain _____
2. Yes No Has there been a change in your health within the last year?
   If YES, explain _____
3. Yes No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain _____
4. Yes No Are you being treated by a physician now? If YES, explain _____
   Date of last medical exam? _____ Reason for exam _____
5. Yes No Have you had problems with prior dental treatment?
   If YES, explain _____
   Date of last dental exam _____ Name of last treating dentist _____
6. Yes No Are you in pain now?
   If YES, explain _____

**II. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (Please Circle)**

| | | |
|---|---|---|
| Chest pain (angina) | Blood in stools | Frequent vomiting |
| Fainting spells | Diarrhea or constipation | Jaundice |
| Recent significant weight loss | Frequent urination | Dry mouth |
| Fever | Difficulty urinating | Excessive thirst |
| Night sweats | Ringing in ears | Difficulty swallowing |
| Persistent cough | Headaches | Swollen ankles |
| Coughing up blood | Dizziness | Joint pain or stiffness |
| Bleeding problems | Blurred vision | Shortness of breath |
| Blood in urine | Bruise easily | Sinus problems |

**III. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please Circle)**

| | | |
|---|---|---|
| Heart disease | AIDS/HIV | Psychiatric care |
| Family history of heart disease | Surgeries | Osteoporosis |
| Heart attack | Hospitalization | Thyroid disease |
| Artificial joint | Diabetes | Asthma |
| Stomach problems or ulcers | Family history of diabetes | Hepatitis |
| Heart defects | Tumors or cancer | Sexual transmitted disease |
| Heart murmurs | Chemotherapy | Herpes |
| Rheumatic fever | Radiation | Canker or cold sores |
| Skin disease | Arthritis, rheumatism | Anemia |
| Hardening of arteries | Emphysema or other lung disease | Liver disease |
| High blood pressure | Kidney or bladder disease | Eye disease |
| Seizures | Stroke | Transplants |
| Cosmetic surgery | Eating disorders | Tuberculosis |

**IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please Circle)**

| | | |
|---|---|---|
| Aspirin | Valium | Tetracycline |
| Darvon | Demerol | Vicodin |
| Codeine | Penicillin | Percodan |
| Local anesthetic (Novacaine or Xylocaine) | Latex | Food |
| Nitrous oxide | Erythromycin | Metal |

Others: _____

**V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS? (Please Circle)**

| | | |
|---|---|---|
| Recreational drugs | Tobacco in any form | Antibiotics |
| Over-the-counter medicines | Alcohol | Supplements |
| Weight loss medications | Bisphosphonate (Fosamax) | Aspirin |

Please list: _____

## VI. WOMEN ONLY

Yes No Are you or could you be pregnant?
If YES, what month? _____

Yes No Are you nursing?

Yes No Are you taking birth control pills?

## VII. ALL PATIENTS

Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, please explain: _____

Yes No Have you ever been pre-medicated for dental treatment? If YES, why _____

Yes No Have you ever taken Fen-phen? If YES, when _____

**Yes No Is there any issue or condition that you would like to discuss with the dentist in private?**

*The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.*

*I authorize the dentist to contact my physician.*

Patient's Signature: _____ Date: _____

Physician's Name: _____ Phone Number: _____

**I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.**

**Signature of Patient (Parent or Guardian)** **Date** **Signature of Dentist** **Date**

……

**MEDICAL UPDATES**
**I have reviewed my Health History and confirm that it accurately states past and present conditions.**

| DATE | PATIENT SIGNATURE | CHANGES TO HEALTH HISTORY | DENTIST INITIALS |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

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## DENTAL HEALTH AND APPEARANCE

Reason for visit: _____ Approximate date of last dental visit: _____
What is your primary concern that you would like us to address first? _____
When would you like us to start treatment? _____
Have you ever had any serious problem associated with previous dental treatment or any dental emergencies?……Yes ❑ No ❑
If so, explain: _____
What, if anything, has happened in previous experiences at the dentist that was reason not to return? _____

_____

Do you have missing teeth?_____ If yes, have you had them replaced?_____
If you have had missing teeth replaced, are you happy with the results? _____
If not, would you like to learn about your options to replace them? _____
Do you ever feel (or have you ever been told) that you don't have fresh breath? _____
How often do you brush your teeth?_____ How often do you floss?_____ What type of brush do you use? Manual ❑ Powered ❑
Do you avoid brushing any part of your mouth because of pain? Yes ❑ No ❑ If yes, what part? _____
Which foods cause you twinges of pain: hot ❑ cold ❑ sweet ❑ sour ❑ none ❑ Do you lose fillings or break fillings?……..Yes ❑ No ❑
Do you chew on only one side of your mouth?……Yes ❑ No ❑ If yes, explain: _____
Do your gums feel tender or swollen?……..Yes ❑ No ❑ Do you usually have many cavities?…….Yes ❑ No ❑
Do you clench or grind your jaws while sleeping or during the day?……Yes ❑ No ❑ Do your jaws ever feel tired?……..Yes ❑ No ❑

We respect your right to choose the level of care that fits *your* needs. We've found that many adults are unaware that problems even exist. There are rarely symptoms (pain, bleeding) associated with the aging and deterioration of teeth and gums – until it is far too late. According to the ADA, more than 80% of adult Americans have some level of gum disease. With your permission we would like to explain the choices available to achieve long-term health and beauty for your existing natural teeth. Please check all that apply:

❑ I desire to keep my own teeth for life, if possible. I want my teeth to look good, feel good, and last for a long time.
❑ Spreading payments out over time may help me to achieve the excellent results I desire.
❑ Phasing treatment, by priority, over a few years may make it feasible for me to achieve the excellent results I desire.
❑ I am interested in a plan for long-term dental health. However, I am currently unable to pursue this, and would appreciate help with emergencies and cleanings for now.
❑ Although I am not interested in a plan for long-term dental health, I do desire an office who will treat teeth in need of immediate/ emergency attention, as well as keep me up to date on cleanings.

## COSMETIC/ESTHETIC EVALUATION

Are you delighted with your smile? _____ Please rate your smile from 1 to 10 (1 = I hate my smile, 10 = awesome)_____
Would you like to have whiter teeth? ❑ Yes ❑ No
If you had a magic wand, what, if anything, would you change about your smile?_____
What (if any) personal or professional benefit might you gain if you had a gorgeous smile? _____
Do you have any special occasions coming up? _____

Through state-of-the-art technology of cosmetic dentistry, we have the ability to help you achieve a world-class smile, often overnight… Using Computer Assisted Dental Imaging and High Resolution Video Photography, we can simulate very closely how YOU would look after the improvements, PRIOR to any treatment! Imaging can be performed as part of your exam visit (at NO additional charge). Would you like to see what YOU would look like with a new and improved smile? Yes ❑ No ❑. If yes, please check off all that apply:

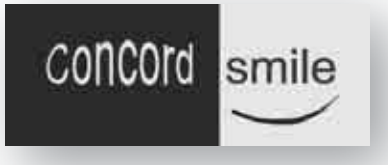
| | | | |
|---|---|---|---|
| ❑ Lighten all front teeth showing | ❑ Rebuild fracture(s) | ❑ Straighten rotation | ❑ Eliminate dark or stained fillings |
| ❑ Lighten single tooth | ❑ Lengthen | ❑ Straighten angulation | ❑ Reduce gum showing in smile |
| ❑ Close spaces between teeth | ❑ Shorten | ❑ Eliminate crowding | ❑ Repair uneven edges |

Please add anything you feel is important: _____

_____

At Concord Smile, though our focus is on appearance-related dentistry, our team also delivers routine general dental care as well. With flexible payment plans as well as phasing treatment over time, you and your family can achieve spectacular long-term results. Thank you so much for the opportunity to be of service.

Warm regards,
Gigi Huynh, DDS




# PATIENT REGISTRATION

Date: _____

Welcome to Concord Smile. Would you please be kind enough to answer the following questions? Thank you so much for being our guest!

M F S M D W

Name (Last) (First) (Middle) Date of Birth Sex Marital Status Social Security Number

How would you like to be addressed? Email Address Cell Phone Number

Home Address (Street) (City) (State) (Zip Code) Home Phone Number

Name of Employer Occupation Driver's License Number

Business Address (Street) (City) (State) (Zip Code) Business Phone Number

## Person Responsible for Account

Who is responsible for account? self spouse parent/guardian other
(Please fill in the following information if the person responsible is different than self.)

Name (Last) (First) (Middle) Social Security Number

Home Address (Street) (City) (State) (Zip Code) Home Phone Number

Name of Employer Occupation Business Phone Number

## Insurance Information

Insured Member (Last) (First) (Middle) Relationship SSN Date of Birth

Name of Employer Occupation Business Phone Number

Business Address (Street) (City) (State) (Zip Code) Dental Insurance Co

Group Number _____ ID Number _____

What are your hobbies? Special interests? _____

How did you hear of Dr. Huynh? _____

If patient was assisted with this form,
Enter name of person assisting: Patient:

Print name Sign name Date Sign name* Date

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