



Brian Klym, DDS

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NorthwoodDentalTC.com

Patient Information & Health History

Patient:

Date:



Note: Correct answers to the following questions will allow Dr. Klym and his staff to treat you on a more individual basis, providing the care appropriate for your particular needs. It will allow Dr. Klym to treat you so there will not be an emergency. However, if an emergency situation does arise, this information will help insure proper treatment. Your answers are for our records only and will be considered confidential.

Date of Last Dental Visit: _____

How often do you brush your teeth? _____

My brush is... Soft Medium Hard

What other dental aids do you use?

Brush Dental Floss Fluoride Other

Check the statement that most applies to you...

1. My mouth is:

Very Comfortable Moderately Comfortable
 Uncomfortable

2. I think the appearance of my mouth is excellent.

I am satisfied with the appearance of my mouth.
 I am dissatisfied with the appearance of my mouth.

3. I will do anything to keep my natural teeth.

I want to keep my teeth, but I have a certain budget of time and money that I am willing to spend on them.

4. I have set goals for my oral health with a previous dentist.

I want to set goals concerning my dental health.

5. I have always done the best that was recommended for my dental health.

I have not done what dentists have recommended to me.
 I rarely go, and don't care much about having any dental work completed.

6. I have put dentistry for myself and family high on my priority list.

I have put dentistry for myself and my family low on my priority list.
 Dentistry is on my list but it's hard to find.

7. I think my present state of dental health is:

Excellent Good Poor

What are some questions about dentistry and your oral health that you never had adequately answered?

Are you having discomfort at this time? Yes No

Does dental treatment make you nervous?

No Slightly Moderately Extremely

What do you fear most about dental care?

These things are important to me about my dental health...

Have you ever had any serious trouble associated with previous dentistry? Yes No

Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? Yes No

Place a mark on "yes" or "no" to indicate if you have ever had any of the following...

Mouth

Bleeding, Sore Gums	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Unpleasant Taste/Bad Breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Burning Tongue/Lips	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Frequent Blister, Lips/Mouth	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Swelling/Lumps in Mouth	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Orthodontic Treatments (Braces)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Biting Cheeks/Lips	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Clicking/Popping Jaw	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Difficulty Opening/Closing Jaw	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Teeth

Loose Teeth	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sensitivity to Cold	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sensitivity to Heat	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sensitivity to Sweets	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sensitivity to Biting	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Food Impaction	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shifting in Bite	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Change in Bite	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Clenching/Grinding	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If so, when: _____



Have you been under the care of a medical doctor during the past two years? Yes No

If yes, for what? _____

Physician's Name: _____

Last Visit to Physician: _____

Do you have high blood pressure? Yes No

What is your normal blood pressure? _____

Are you allergic or have you had a reaction to the following...

- Local Anesthetic Yes No
- Penicillin or Other Antibiotics Yes No
- Aspirin, Ibuprofen or Tylenol Yes No
- Codeine, Valium® or Other Sedatives Yes No
- Latex or Metals Yes No

Have you ever had an allergic or adverse reaction to any medication or substance (including foods)? Yes No

If yes, please list: _____

Are you currently taking any medications, drugs or pills?

Yes No

If yes, please list name and dosage:

Do you use tobacco? Chew Smoke

How often? _____ How long? _____

Do you consume alcohol? Yes No

How many beverages per week? _____

Do you use any mood altering drugs other than those previously listed? Yes No

Check yes or no to indicate whether or not you have had or now have the following conditions or treatments:

- | | | |
|---|--|--|
| Heart Condition <input type="checkbox"/> Yes <input type="checkbox"/> No | Contact Lenses <input type="checkbox"/> Yes <input type="checkbox"/> No | Cortisone Medicine <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Attack <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No | Arthritis/Rheumatism <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No | Bruise Easily <input type="checkbox"/> Yes <input type="checkbox"/> No | Fen-Phen or Redox <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chest Pain (Angina) <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No | Special or Restricted Diet <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Chronic Cough <input type="checkbox"/> Yes <input type="checkbox"/> No | Latex Sensitivity <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis (T.B.) <input type="checkbox"/> Yes <input type="checkbox"/> No | Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Mitral Valve Prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No | Hay Fever <input type="checkbox"/> Yes <input type="checkbox"/> No | Chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valve <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No | Allergies or Hives <input type="checkbox"/> Yes <input type="checkbox"/> No | Neurological Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous/Anxious <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis Type _____ <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy or Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No | Yellow Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting or Dizzy Spells <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hemophilia <input type="checkbox"/> Yes <input type="checkbox"/> No | AIDS <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric/Psychological Care <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV Positive <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alcoholism <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Artificial Joints or Heart Valves <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Drug Addiction <input type="checkbox"/> Yes <input type="checkbox"/> No | Cold Sores/Fever Blisters <input type="checkbox"/> Yes <input type="checkbox"/> No | Sickle Cell Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood Transfusion <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Family History of Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Bone Disease or Bone Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Swollen Ankles <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Any disease, condition or problem not listed: _____

Women

Are you pregnant or planning a pregnancy? Yes No

If yes, due date: _____

Are you a nursing mother? Yes No

Are you taking birth control pills? Yes No

Date: _____

Patient

Social Security Number: _____

Driver's License Number: _____

Patient Name: _____
First Last
Initial Nickname

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Work: _____ Cell: _____

Email: _____

Gender: Male Female

Age: _____ Birthdate: _____

Parent/Guardian: _____

Employment/School

Occupation: _____

Employer/School: _____

Address: _____

City: _____

State: _____ Zip: _____

Phone: _____

Emergency Notification

Name: _____

Relationship: _____

Phone: _____

How did you hear about Dr. Klym? *Please check all that apply.*

- Family Friend Postcard Billboard
- Radio/TV Phonebook Other: _____

Insurance

Subscriber's Name: _____

Subscriber's Date of Birth: _____

Relationship: _____

Social Security Number: _____

Employer: _____

Insurance Company: _____

Group #: _____

Address: _____

City: _____ State: _____ Zip: _____

Dual Coverage: Yes No *If yes, please complete the following.*

Subscriber's Name: _____

Subscriber's Date of Birth _____

Relationship: _____

Social Security Number: _____

Employer: _____

Insurance Company: _____

Group #: _____

Address: _____

City: _____ State: _____ Zip: _____

Payment Policy

Payment is due at time of service. We accept cash, personal checks from local banks, MasterCard, Visa, Discover, and CareCredit. We will bill your insurance and you are responsible for all uncovered charges. Charges not paid within 60 days, including insurance payments not paid, will have a service charge of 1.5% per month (annual rate of 18%) added to the balance each month thereafter. I agree to be responsible for all fees.

To the best of my knowledge all the preceding answers are true and correct. I will inform your office of any changes at the next appointment.

Signature of Patient or Guardian

Date:

