KLAHANIE
FAMILY DENTISTRY
TRAVIS M. HOWEY, DDS

PATIENT'S NAME: _____
Home Address: _____
_____
City State Zip
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Email: _____
Employer: _____
Business Address: _____
_____
City State Zip

Social Security Number: _____
Date of Birth: _____ Age: ____

Marital Status: _____

Dental Insurance:
Insurance Company: _____
Address: _____
Group Number: _____
ID Number: _____

Person responsible for this account:
_____

SPOUSES NAME: _____
Employer: _____
Address: _____
Work Phone: _____
Cell Phone: _____

Social Security Number: _____
Dental Insurance:
Insurance Company: _____
Address: _____
Group Number: _____
ID Number: _____

Previous Dentist: _____
Location: _____
Phone: _____

Physicians Name: _____
Location: _____
Phone: _____

Emergency Contact: _____
Address: _____
Phone: _____

May we request your previous dental records?Y N

Have you had a full mouth survey of X-rays taken within the past three years? Y N

How did you hear of our office?_____

I certify that the above, and following Medical and Dental information is current and correct and that I will notify this office of any changes.

Patients Signature:_____ **Date:**_____
(Parent or Guardian of patient if under age 18)

It is extremely important that we know about your Dental and Medical history. There are many medical situation which can affect or be affected by procedures or medications used in dentistry. Information given to us is strictly confidential and will not be released without your written permission. Please answer all of the following questions and explain all "Yes" answers.

DENTAL HISTORY

1. **What is your chief dental concern at this time?** (Any discomfort?) _____
   _____
2. **How long has it been since your last dental visit? _____** Has your dental care been regular or sporadic during your lifetime? _____
3. **Are your teeth sensitive to hot, cold, sweets or pressure? _____**
   _____
4. **Are you happy with your smile?** (Tooth size, shape, position, shape, position, color?) _____
   _____
5. **Have you ever had Orthodontic Treatment** (braces)?
   _____
6. **Have you ever had any injuries to your teeth or jaw joints? _____**
7. **Do your gums bleed easily?** (Do you floss your teeth?)
   _____
8. **Does food wedge between your teeth and cause discomfort in a particular area? _____**
9. **Do you have any fears about dental treatment? _____** Would you consider yourself a dentaphobic? _____ Would you like to be sedated for your appointments? ____ (N20-laughing gas or Valium?) _____
10. **Have you had any unusual experiences resulting from dental care? _____**
    _____

MEDICAL HISTORY

1. **Date of last medical exam? _____**
2. **Are you under a physician's care? _____**
3. **Have you ever had a serious illness, operation, or been hospitalized? _____**
4. **Have you ever been treated for psychiatric illness, or seen a psychologist for any reason? _____**
5. **Do you currently smoke or use tobacco products? ____** If yes, how many packs a day? _____ For how many years? _____ Have you ever used these products? How long? _____
6. **Women:** Are you taking birth control pills? _____ Are you currently pregnant or is there a chance you may be? _____ Are you nursing? _____ Are you taking any hormone supplements? _____
7. **Name any medication and its purpose taken in the last year. _____**
   _____
8. **Do you have any allergies to any medication or materials? _____**
   _____
9. **Do you have a heart murmur or any artificial prosthesis that requires that you receive antibiotics prior to dental treatment? _____**
   _____
   _____

Do you have or have you had any of the following? (Please indicate with an "X")

- ❑ Chest pain / Angina pectoris
- ❑ Heart attack
- ❑ Rheumatic fever
- ❑ High blood pressure
- ❑ Stroke or transient weakness
- ❑ Fainting or dizzy spells

_____

- ❑ Venereal Disease (Syphilis, Gonorrhea, Chlamydia)
- ❑ Herpes I (Cold sores)
- ❑ Herpes II (Genital)
- ❑ HIV / AIDS
- ❑ Vincent Disease (Trench mouth)
- ❑ Hepatitis (A, B, or C)
- ❑ Blood transfusion
- ❑ Drug abuse
- ❑ Alcoholism
- ❑ Liver disease or jaundice
- ❑ Excessive bleeding/ Hemophilia
- ❑ Leukemia
- ❑ Anemia
- ❑ Tuberculosis
- ❑ Emphysema
- ❑ Asthma
- ❑ Sinus problems/infections
- ❑ Hay fever or allergies
- ❑ Stomach ulcer
- ❑ Intestinal problems/ colitis
- ❑ Kidney disease
- ❑ Prostate disease
- ❑ Seizure disorder/ epilepsy
- ❑ Thyroid disease
- ❑ Diabetes
- ❑ Arthritis
- ❑ Glaucoma
- ❑ Hearing problems
- ❑ Chemotherapy
- ❑ Radiation/ cobalt treatment
- ❑ Other

Review Date	Changes

Medication List:

Please list all medications you are currently taking.

***We ask this because we want to provide the best care for our patients as well as ensure the safety of each patient.**

Name	Dosage