PAUL C. HEILMAN, DDS
GENERAL DENTISTRY

NOTE: Please print, complete and mail or fax these forms to our office prior to your visit. It is not advised to email the forms to us as email servers are not a secure method of transmitting personal information.

Welcome ~ we want to get to know you better!

PATIENT NAME _____ PHONE _____ CELL/PAGER/BEEPER _____

ADDRESS _____ CITY _____ STATE/ZIP _____

DATE OF BIRTH _____ SOCIAL SECURITY # _____

E-MAIL (HOME): _____ E-MAIL (WORK): _____

MARITAL STATUS: _____ SINGLE _____ MARRIED SPOUSE'S NAME _____

EMPLOYER _____ WORK PHONE _____

ADDRESS _____ CITY _____ STATE/ZIP _____

PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

IF YOU HAVE DENTAL INSURANCE:

INSURED NAME _____ INSURED'S ID/SSN _____ INSURED'S BIRTHDATE _____

INSURED'S EMPLOYER _____ INSURANCE CO PHONE NUMBER _____

MEDICAL HISTORY

DO YOU HAVE ANY GENERAL HEALTH PROBLEMS? IF SO, PLEASE SPECIFY: _____

_____

_____

ARE YOU CURRENTLY UNDER A PHYSICIAN'S CARE? _____ REASON: _____

NAME AND ADDRESS OF PHYSICIAN: _____

HAVE YOU BEEN HOSPITALIZED IN THE PAST 3 YEARS? _____ IF YES, FOR WHAT REASON? _____

TO THE BEST OF YOUR KNOWLEDGE, ARE YOU OR HAVE YOU EVER BEEN AFFLICTED WITH: (PLEASE CHECK)

YES	NO		YES	NO		YES	NO	
_____	_____	HEART ATTACK/DISEASE When:_____	_____	_____	RESPIRATORY DISEASE	_____	_____	OSTEOPOROSIS
_____	_____	HEART MURMUR	_____	_____	DIABETES Type:_____	_____	_____	TUBERCULOSIS
_____	_____	HIGH BLOOD PRESSURE	_____	_____	KIDNEY/LIVER DISEASE	_____	_____	ANOREXIA/BULEMIA
_____	_____	MITRAL VALVE PROLAPSE	_____	_____	EPILEPSY/SEIZURES	_____	_____	BLOOD/CLOTTING DISORDER
_____	_____	RHEUMATIC FEVER	_____	_____	ARTHRITIS	_____	_____	HEALING COMPLICATIONS
_____	_____	STROKE When:_____	_____	_____	ANY FORM OF HEPATITIS	_____	_____	DRUG ABUSE/ALCOHOLISM
_____	_____	THYROID PROBLEMS	_____	_____	HUMAN PAPILLOMAVIRUS (HPV)	_____	_____	HIV/AIDS
_____	_____	EVER TAKEN PHEN/FEN MEDS	_____	_____	GLAUCOMA	_____	_____	AUTOIMMUNNE DISEASE
_____	_____	ARTIFICIAL JOINT REPLACEMENT	_____	_____	TOBACCO	_____	_____	CANCER
		When: _____ Joint: _____			Use _____/Day _____			When: _____ Type: _____
_____	_____	HIGH STRESS	_____	_____	OTHER (please explain):_____			
_____	_____	ALLERGY TO ANY MEDICATIONS List: _____						

[CONTINUED]

WOMEN: ARE YOU PREGNANT? _____ YES _____ NO _____ MAYBE DUE DATE: _____

DO ANY OF THESE, OR ANY OTHER CONDITION, REQUIRE PRE-MEDICATIONS PRIOR TO DENTAL TREATMENT? _____ YES _____ NO

HAVE YOU EVER TAKEN CORTICOSTERIODS (2MG OR MORE) FOR AT LEAST A 2 WEEK PERIOD OF TIME WITHIN THE LAST 2 YEARS? _____ YES _____ NO

HAVE YOU EVER TAKEN BISPHOSPHONATES (SUCH AS ACTONEL, BONIVA, RECLAST, ZOMETA OR FOSAMAX)? _____ YES _____ NO

DO YOU HAVE ANY OTHER DISEASE, CONDITION OR PROBLEM NOT LISTED? IF SO, PLEASE EXPLAIN _____

_____

_____

ARE YOU CURRENTLY TAKING, OR SUPPOSED TO BE TAKING, ANY DRUGS? (PRESCRIPTION, OVER THE COUNTER, RECREATIONAL)? _____ YES _____ NO

	NAME OF MEDICATION	REASON FOR TAKNG	DOSAGE	DOCTOR
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				

SIGNATURE _____ DATE _____

[CONTINUED]

DENTAL HISTORY

1. What prompted you to seek dental care at this time? _____

2. When was your last dental appointment? _____

3. What did you have done? _____

YES NO

_____ _____ 4. Has the fear of discomfort kept you from regular dental visits?

_____ _____ 5. Do you want to learn to control dental disease and retain your teeth?

_____ _____ 6. Have you been instructed regarding proper home care?

_____ _____ 7. Do you ever avoid any part of your mouth while brushing?

_____ _____ 8. Do your gums *ever* bleed when you brush?

_____ _____ 9. Do you have an unpleasant taste or odor in your mouth?

_____ _____ 10. Are your teeth sensitive to: _____ Heat? _____ Cold?
_____ Sweets? _____ Biting Pressure?

_____ _____ 11. Does food constantly get stuck between certain teeth in your mouth?

_____ _____ 12. Have you ever had any teeth removed?

_____ _____ 13. How long have these teeth been missing? _____

_____ _____ 14. Have these teeth been replaced? How? _____Bridge _____ Partial Denture _____ Denture _____ Implants

_____ _____ 15. Are you pleased with the replacement(s)?

_____ _____ 16. Do any of your fillings show when you smile?

_____ _____ 17. If any of your silver amalgam filings need replacement, would you prefer to have a more natural, tooth-colored restoration instead?

_____ _____ 18. Do you get frustrated because you always have something to be treated or repaired when you visit a dentist?

_____ _____ 19. Are you dissatisfied with your teeth in any way? (For example, color, shape, spaces, etc.)

_____ _____ 20. Are you deeply concerned about the finances required to return your mouth to excellent dental health?

21. How often do you brush your teeth? _____

22. How often do you floss? _____

REMARKS: _____

_____

_____

_____

I authorize Dr. Heilman to use photographs, radiographs, other diagnostic materials and treatment records for the purposes of teaching, research and scientific publications.

SIGNATURE _____ DATE _____

[*THANK YOU!*]

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