Dr.Miller and Dr.Lee Periodontics

www.westernctperio.com
hsmillerdmd@gmail.com
8 Walnut Street • Danbury, CT 06811
(203)748-8114

Patient Record

In order for me to render the proper dental services to you, would you please be kind enough to answer the following questions.

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **Prev. Visit:** _____ **Email Address:** _____

Phone: _____ _____ _____ _____ **Best time to call:** _____
Home Mobile Work Ext

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Occupation _____

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **Email Address:** _____

Phone: _____ _____ _____ _____ **Best time to call:** _____
Home Mobile Work Ext

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Dental Insurance

Name of Insured: _____ _____ ___
Last First MI

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Response Date: ____/____/_____

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Patient Health Record

In order for me to render the proper dental services to you, would you please be kind enough to answer the following questions.

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Date of Birth _____

Are you being treated by a physician now? ◯ Yes ◯ No

Name of Primary Care Physician and Any medical treatment in Past 5 years

_____

_____

Have you experienced:

- ☐ Chest pain (angina)
- ☐ Recent weight loss, fever, night sweats
- ☐ Sinus problems
- ☐ Frequent vomiting nausea
- ☐ Ringing in ears
- ☐ Seizures
- ☐ Jaundice
- ☐ Swollen Ankles
- ☐ Persistent cough, coughing up blood
- ☐ Difficulty swallowing
- ☐ Difficulty urinating, blood in urine
- ☐ Headaches
- ☐ Excessive thirst, Frequent Urination
- ☐ Joint pain stiffness
- ☐ Shortness of breath
- ☐ Bleeding problems, bruising easily
- ☐ Diarrhea, constipation, blood in stools
- ☐ Dizziness, Fainting spells
- ☐ Blurred vision
- ☐ Dry mouth

Have you ever been treated for

- ☐ Heart Disease
- ☐ Low Blood Pressure
- ☐ Diabetes
- ☐ Osteoprosis (Bisphosphonates)
- ☐ Mental Disorder
- ☐ Asthma or Hayfever
- ☐ Cancer
- ☐ STD (Syphilis or gonorrhea)
- ☐ Anticoagulation Medication
- ☐ None of Above
- ☐ Heart Attack
- ☐ Stroke
- ☐ High Cholesterol
- ☐ Blood Disease
- ☐ Kidney or Bladder Disorder
- ☐ Sinus
- ☐ Radiation/Chemotherapy therapy
- ☐ Herpes
- ☐ Sleep Apnea
- ☐ Rheumatic Fever
- ☐ Heart Murmur
- ☐ Dementia
- ☐ Anemia
- ☐ Ulcers
- ☐ Arthritis
- ☐ Tumors, cancer
- ☐ Kidney, Bladder disease
- ☐ (Women) Pregnant
- ☐ High Blood Pressure
- ☐ Pace maker
- ☐ Tuberculosis or Lung diseaes
- ☐ Epilepsy
- ☐ Hepatitis, Liver Disease
- ☐ Artificial Joint
- ☐ AIDS
- ☐ Thyroid, adrenal disease
- ☐ (Women) Birth Control Pills

Are you allergic to any of following?

☐ Local Anesthetic ☐ Penicillin ☐ Other Antibiotic ☐ Aspirin ☐ Sleeping Pills ☐ Codeine ☐ Latex

Are you taking:

- ☐ Recreational drugs
- ☐ Tobacco in any form
- ☐ Drugs, medications, over the counter medication, natural remedies
- ☐ Alcohol

Do you have or have you had any other disease or medical problems not listed on this form? If so, please explain:

_____

_____

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 medication.

Signature _____ **Date** _____

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Patient Health Record

In order for me to render the proper dental services to you, would you please be kind enough to answer the following questions.

Dental Health

When was you last dental visit and what is reason for visit for today?

_____

_____

Name Previous Dentist _____

When did you last have your teeth professionally cleaned? _____

What kind of tooth bursh do you use?

◯ Ultrasoft ◯ Soft ◯ Medium ◯ Hard ◯ Electronic

Do you use floss/proximal brush? ◯ Yes ◯ No

Have you ever experienced?

- ☐ Gum Bleeding during brushing or flossing
- ☐ Difficulty or pain when chewing
- ☐ Noticed any loose teeth or shifting teeth
- ☐ Gingival recession or gum loss
- ☐ Nervouness during dental visit
- ☐ Gagging easily
- ☐ Avoid Brushing any part of your mouth because of pain
- ☐ Tender or sweollen gum
- ☐ Tooth Senstivity
- ☐ Noticed any mouth orders or bad tates
- ☐ Serious trouble during dental visit
- ☐ Cleanching or Grding your jaws while sleeping or during the day

Have you had the missing teeth replaced?

☐ Denture ☐ Bridge ☐ Dental Implant

Response Date: ____/____/_____