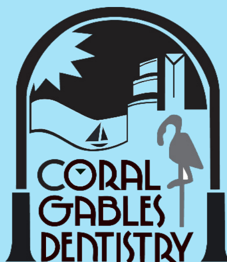
PATIENT HEALTH RECORD

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

Thank you for your cooperation.



GORDON D. SOKOLOFF, D.D.S., P.A.
3326 Ponce de Leon Boulevard
Coral Gables, FL 33134
Telephone (305) 567-1992
Fax (305) 567-9598

DATE

NAME (Last) (First) (Middle) (Home Phone)

HOME ADDRESS Street City State Zip Mobile/Cellular

BUSINESS ADDRESS Street City State Zip Business Phone

E-MAIL ADDRESS EMERGENCY CONTACT NAME EMERGENCY CONTACT PHONE

DATE OF BIRTH SEX HEIGHT WEIGHT OCCUPATION

MARITAL STATUS (Check) ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED SPOUSE'S NAME: ____________

TYPE OF DENTAL INSURANCE (If applicable) NAME & SOCIAL SECURITY NO. OF INSURED PATIENT SOCIAL SECURITY NO.

REFERRED BY PATIENT DRIVER LICENSE NO. IF PATIENT IS MINOR - LEGAL GUARDIAN

MEDICAL HEALTH

General Health (please check): ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

Name and address of physician ____________

Last complete physical? ____________

(Please circle Yes or No)

ARE YOU TAKING ANY MEDICATION NOW? YES NO → **PLEASE SPECIFY** ____________

ARE YOU BEING TREATED OR HAVE YOU EVER BEEN TREATED FOR:

Condition			Condition		
Heart disease	YES	NO	Heart murmur	YES	NO
Rheumatic fever	YES	NO	Jaundice	YES	NO
Abnormal blood pressure	YES	NO	Asthma or hay fever	YES	NO
Ulcers	YES	NO	Sinus trouble	YES	NO
Tuberculosis or Lung disease	YES	NO	Chronic or persistent cough	YES	NO
Diabetes	YES	NO	Hepatitis	YES	NO
Epilepsy	YES	NO	Arthritis	YES	NO
Anemia	YES	NO	Stroke	YES	NO
Congenital Heart Lesions	YES	NO	Glaucoma	YES	NO
A.I.D.S. or H.I.V. Positive	YES	NO	Gonorrhea	YES	NO
Herpes simplex virus	YES	NO	Syphilis	YES	NO
Prolapse Mitral Valve	YES	NO	Artificial Implants or Prosthetics (i.e. heart valve. joint replacement)	YES	NO
Human Papilloma Virus (HPV)	YES	NO	Cancer or Radiation treatment	YES	NO
Pneumonia	YES	NO	Difficulty breathing at night (Apnea)	YES	NO

Are you allergic to: ☐ Penicillin ☐ Codeine ☐ Local injected anesthetics ☐ Other medications ____________

Are you subject to prolonged bleeding? YES NO

Are you subject to fainting spells? YES NO

Do you have excessive urination and/or thirst? YES NO

(women)

Are you pregnant YES NO How long? ____________

Are you nursing YES NO

DENTAL HEALTH

(Please circle Yes or No)

Reason for visit ___

When was your last dental visit? ___

Have you ever had any serious problem associated with previous dental treatment? .... YES NO

If so, please explain: ___

___

How often do you brush you teeth? ___

What texture brush do you use? SOFT MEDIUM HARD NYLON NATURAL

How often do you floss? ___

Do your gums bleed while brushing? .... YES NO

Do your gums bleed while flossing? .... YES NO

Do you avoid brushing any part of your mouth because of pain? .... YES NO

If yes, what part? ___

Do you feel twinges of pain when your teeth come in contact with:

- a) hot foods or liquids, i.e., soup, coffee, tea, etc.? .... YES NO
- b) cold foods or liquids, ice cream, cold fruit, etc.? .... YES NO
- c) sweets, i.e. candy, fruit, sweet desserts, etc.? .... YES NO
- d) sours, i.e., lemons, limes, grapefruit, etc.? .... YES NO

Do you feel pain to any of your teeth when brushing or flossing them? .... 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 clench or grind your jaws while sleeping or during the day? .... YES NO

Do your jaws ever feel tired? .... YES NO

Do you wear dentures? .... YES NO

Do you usually have many cavities? .... YES NO

Do you lose fillings or break fillings? .... YES NO

Do you gag easily? .... YES NO

Do you smoke or chew tobacco? .... YES NO

Are you familiar with the term "preventive dentistry"? .... YES NO

Please add anything you feel is important: ___

___

___

___

Patient Signature (Guardian if Minor)

RECALL UPDATE VERIFICATION

I have reviewed this health history and made all necessary additions, corrections and/or changes to bring this form up to date.

DATE	INITIAL	DATE	INITIAL	DATE	INITIAL	DATE	INITIAL