DENVER INDIAN HEALTH AND FAMILY SERVICES, INC.

2880 W. Holden Pl Denver, Co 80204 PH: (303) 953-6600 FAX: (303) 781-4333 www.dihfs.info

DENTAL HEALTH HISTORY FORM

PATIENT INFORMATION

Date: _____ Telephone: _____

Name: _____ Date of Birth: _____

Address: _____

_____

CITY ST ZIP CODE

Reason for visit: _____

PREVIOUS DENTIST INFORMATION

Dentist: _____ Telephone: _____

Clinic/Facility: _____

Address: _____

_____

CITY ST ZIP CODE

Reason for changing: _____

DENTAL HISTORY

ORAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

Date of Last Dental Visit: _____ Treatment Type: _____

Would you like to have a VisiLite oral cancer screening? ☐Y☐N

**Note: Some insurance plans do not cover this service; please check your plan documents for details.*

☐Y☐N Are you currently having dental discomfort? If yes, explain: _____

☐Y☐N Any unhappy/unpleasant dental experiences? If yes, explain: _____

☐Y☐N Any injuries to mouth/teeth/head? If yes, explain: _____

☐Y☐N Any missing teeth other than wisdom teeth or orthodontic extractions?

☐Y☐N Have missing teeth been replaced?

☐Y☐N Orthodontic appliances now or in the past?

☐Y☐N Gums bleed when brushing or flossing?

☐Y☐N Concerned about gum disease? History of gum disease? ☐Y☐N

☐Y☐N Any concerns about the appearance of your teeth?

☐Y☐N Does it hurt to bite or chew?

☐Y☐N Do you clench or grind your teeth? If so, do you wear a night guard or splint? ☐Y☐N

☐Y☐N Do you want to become a regular continuing care patient in our practice?

☐Y☐N Do you want your mouth properly restored and pain free?

☐Y☐N Does any type of dental treatment make you nervous? If yes, please explain below:

_____

The most important concerns regarding my dental treatment are:

_____

What factors are most important for your satisfaction with our office?

_____

Any additional concerns/comments?

_____

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CHILD/MINOR PATIENTS: PLEASE ANSWER THE FOLLOWING QUESTIONS:

☐Y☐N Any mouth habits? (thumb sucking, nail biting, mouth breathing, nursing/bottle habits, pacifier, etc.)

☐Y☐N Any unusual speech habits? If yes, explain:

☐Y☐N Any lost teeth? If yes, list:

☐Y☐N Does the patient receive assistance with brushing and flossing? If yes, how often?

DENTAL HEALTH HISTORY FORM

PRIMARY PHYSICIAN INFORMATION

Physician: Telephone:

Clinic/Facility:

MEDICAL HISTORY

GENERAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

☐Y☐N Under a physician's care now?

☐Y☐N Any hospitalization in the past 5 years?

☐Y☐N Any serious illnesses/surgeries?

☐Y☐N Use tobacco in any form? If Yes, Type:

☐Y☐N Is pre-medication required before dental visits due to heart condition or artificial joint?

☐Y☐N Taking any prescription or daily OTC medications/drugs? *If yes, list details in the Medication Section.*

FEMALE PATIENTS: ☐Y☐N Currently nursing? ☐Y☐N Currently pregnant? Due Date:

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients? ☐Y☐N
If yes, please describe:

Is there anything important about your medical condition we have not asked? ☐Y☐N If yes, please describe:

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ACID REFLUX	☐BULIMIA	☐HEARING PROBLEMS	☐PSYCHIATRIC TREATMENT
☐ADHD	☐CANCER/MALIGNANCY	☐HEART ATTACK	☐RADIATION/CHEMO
☐AIDS/HIV	☐CEREBRAL PALSY	☐HEART DISEASE	☐RESPIRATORY DISEASE
☐ANEMIA	☐CHEMICAL DEPENDENCY	☐HEART MURMUR	☐RHEUMATIC FEVER
☐ANOREXIA	☐CHICKEN POX	☐HEPATITIS	☐SINUS PROBLEMS
☐ANXIETY	☐CONVULSIONS	☐HIGH BLOOD PRESSURE	☐STROKE
☐ARTIFICIAL HEART VALVE	☐DEPRESSION	☐KIDNEY DISEASE	☐THYROID CONDITION
☐ARTIFICIAL JOINTS	☐DIABETES	☐LIVER PROBLEMS	☐TUBERCULOSIS
☐ARTHRITIS	☐DIZZINESS/FAINTING	☐MITRAL VALVE PROLAPSE	☐ULCERS
☐ASTHMA	☐EPILEPSY/SEIZURES	☐MONONUCLEOSIS	☐VENEREAL DISEASE
☐AUTISM/ASPERGER'S	☐FREQUENT EAR INFECTIONS	☐PACEMAKER	
☐BLEEDING DISORDER	☐ FREQUENT HEADACHES	☐OTHER – PLEASE LIST:	

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):

☐ASPIRIN	☐CODEINE	☐LACTOSE INTOLERANCE	☐SLEEPING PILLS	☐NONE
☐ANESTHETIC – LOCAL	☐DAIRY	☐METAL SENSITIVITY	☐SULFA DRUGS	
☐BARBITURATES	☐LATEX	☐NITROUS OXIDE SEDATION	☐PENICILLIN/OTHER ANTIBIOTICS	
☐OTHER – PLEASE LIST:				

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MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY):

☐ NONE

☐ ANTIBIOTICS/SULFA DRUGS ☐ ANTIHISTAMINES/ALLERGY ☐ DAILY ASPIRIN ☐ BLOOD PRESSURE MEDICATIONS
☐ BLOOD THINNERS ☐ CANCER/CHEMO MEDICATIONS ☐ CORTISONE/STEROIDS ☐ HEART MEDICATION/DIGITALIS
☐ INSULIN ☐ NITROGLYCERIN ☐ ORAL CONTRACEPTIVES ☐ OSTEOPOROSIS MEDICATIONS

☐ OTHER DIABETIC MEDICATIONS ☐ RECREATIONAL DRUGS ☐ THYROID MEDICATIONS ☐ TRANQUILIZERS
☐ OTHER (PLEASE LIST BELOW)

DRUG NAME	DOSAGE	REASON PRESCRIBED

PATIENT AND (DIHFS) STAFF SIGNATURES

Date: Patient Signature:

Date: Reviewed By: