MARK D BERMAN, D.D.S. ASSOCIATES
44200 GARFIELD SUITE 100 CLINTON TOWNSHIP, MI 48038
586.263.0770

Patient Health History

Name: ______________________ **BirthDate:** ____________ **Sex:** **M** **F**

Name of person to contact in case of emergency: ______________________

Phone # of person to contact in case of emergency: ______________________

Thank you for answering the following accurately and completely for your health's sake!

Are you allergic to Latex? Yes No

Do you have a fruit or nut allergy? Yes No

Are you allergic to any medications? Yes No

If so, please list: ______________________

Are you currently taking any medications? Yes No

If so, please list: ______________________

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Are you having pain or discomfort at this time? Yes No

Have you ever chipped or broken a tooth or had biting sensitivity? Yes No

Have you had any cavities in the past three years? Yes No

Have you noticed notches forming on your teeth near the gum line? Yes No

Does it feel like you have a dry mouth or have difficulty swallowing? Yes No

Do you have any hot, cold, sweet or brushing sensitivity? Yes No

Do you get food caught between your teeth? Yes No

Do your gums bleed or are they painful when brushing or flossing? Yes No

Have you ever been treated for gum disease or been told you have lost bone around your teeth? Yes No

Have you ever noticed an odor or bad taste in your mouth? Yes No

Do you frequently have bad breath? Yes No

Have you ever experienced gum recession? Yes No

Have you ever had a tooth become loose or have difficulty eating a carrot or other hard foods? Yes No

Do you have any pain, clicking or popping in your jaw joint? Yes No

Have you noticed any changes in your teeth in the past 5 years? Yes No

Have they become more worn, thinner or shorter? Please describe: ______________________

Are your teeth becoming more crooked or crowded? Yes No

Do you feel like your teeth have more space between them or are loose? Yes No

Do you clench your teeth in the daytime? Yes No

Has anyone ever told you you grind your teeth or do you wake up with headaches or jaw soreness? Yes No

Have you ever worn a night guard? Yes No

Is there anything about the appearance of your teeth that you would like to change? Yes No

Have you ever bleached your teeth? Yes No

Have you ever felt self conscious about the appearance of your teeth? Yes No

Have you been disappointed with the appearance or outcome of previous dental work? Yes No

Would you like your treatment done under Nitrous Oxide Gas? Yes No

Please complete reverse side

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Name: ____________________ **BirthDate:** ____________ **Sex:** **M** **F**

Medical History

Have you been under the care of a medical doctor during the past 2 years? Yes No

Have you been a patient in the hospital during the past 2 years? Yes No

Have you ever been treated for osteoporosis? Yes No

Have you ever had any excessive bleeding requiring special treatment? Yes No

When you walk up stairs or take a walk, do you have to stop due to shortness of breath? Yes No

Are you on a special diet? Yes No

Do you smoke? Yes No If so, how many packs per day? For how many years?

Women: Are you pregnant now? Are you taking oral contraceptives?

Do you anticipate becoming pregnant?

Please circle any of the following which you have had or have at present:

Heart Failure	High Blood Pressure	Asthma	Arthritis
Heart Disease or Attack	Stroke	Cough	Rheumatism
Angina Pectoris	Rheumatic Fever	Chronic Bronchitis	Artificial Joints
Heart Murmur	Scarlet Fever	Emphysema	Muscular Sclerosis
Heart Surgery	Kidney Trouble	Tuberculosis (TB)	Anemia
Congenital Heart Lesions	Ulcers	Sinus Trouble	Bruise easily
Artificial Heart Valve	Acid Reflux/Gerd	Allergies or Hives	Hemophilia
Mitral Valve Prolapse	Diabetes	Hay Fever	Cortisone medicine
Heart Pacemaker	Thyroid Disease	Hepatitis	Cold Sores
X-ray or Cobalt Treatment	Epilepsy or seizures	Liver Disease	Genital Herpes
Chemotherapy (cancer,	Fainting or dizzy spells	Yellow Jaundice	AIDS
leukemia)	Nervousness	Blood Transufion	Venereal Disease
Sickle cell disease	Psychiatric Treatment	Glaucoma	Drug/alcohol abuse

Has your medical doctor ever said you have a cancer or tumor? Yes No

Do you have any disease, condition or problem not listed? Yes No

Please List:

To the best of my knowledge, all of the preceding answers are true and correct. I understand that providing incorrect information can be dangerous to my (or patient's) health. If I ever have any change in my health, or if my medications change, I will inform the doctor of dentistry at the next appointment without fail. I authorize the dentist to release information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to other health practitioners and/or third party payors.

____________ ______________________________

Date Signature of patient, parent or guardian

Please complete reverse side