RICHARD L. LACHENMAYR D.M.D.
FAMILY DENTISTRY
1150 Third Avenue, Suite 2 • Alpha, New Jersey 08865
(908) 454-8400 FAX (908) 454-8443

Patient History Form

Welcome to our office! So that we may provide you with the best possible care, please complete both sides of this form. All information is completely confidential.

Patient Information - General & Registration

PATIENT NAME

PATIENT ADDRESS

PATIENT CITY, STATE, ZIP

HOME PHONE: **WORK** **CELL**

PATIENT SOCIAL SECURITY NUMBER | DRIVER'S LICENSE NUMBER

PATIENT AGE: | PATIENT BIRTHDATE | GENDER

PATIENT OCCUPATION | PATIENT EMPLOYER

PRIMARY INSURED'S EMPLOYER

PRIMARY DENTAL INSURANCE CO. | GROUP NUMBER | INSURED'S NAME | INSURED'S DATE OF BIRTH | INSURED S.S.N.

SECONDARY INSURED'S EMPLOYER

SECONDARY DENTAL INSURANCE CO. | GROUP NUMBER | INSURED'S NAME | INSURED'S DATE OF BIRTH | INSURED S.S.N.

Responsible Party Information

PARENT NAME (IF PATIENT IS CHILD)

PARENT ADDRESS

PARENT CITY, STATE, ZIP

HOME PHONE WORK CELL

PARENT SOCIAL SECURITY NUMBER

PATIENT MEDICAL ALERT

PATIENT EMPLOYER ADDRESS

PRIMARY INSURED'S EMPLOYER ADDRESS

SECONDARY INSURED'S EMPLOYER ADDRESS

Patient Information - Dental History

WHAT IS THE REASON FOR YOUR VISIT TODAY? ARE YOU HAPPY WITH YOUR SMILE?

DATE OF LAST DENTAL VISIT | LAST DENTAL CLEANING | DATE OF LAST FULL MOUTH X-RAYS (16-18 LITTLE FILMS)

WHAT WAS DONE ON YOUR LAST DENTAL VISIT?

PREVIOUS DENTIST'S NAME | TELEPHONE NUMBER

WHY DID YOU LEAVE YOUR LAST DENTIST?

HOW OFTEN DO YOU BRUSH YOUR TEETH? | HOW OFTEN DO YOU FLOSS? | WHAT OTHER DENTAL AIDS DO YOU USE? (TOOTHPICK, ROTADENT, ETC.)

ARE ANY OF YOUR TEETH SENSITIVE TO: HEAT OR COLD? YES ☐ NO ☐ SWEETS? YES ☐ NO ☐
BITING OR CHEWING? YES ☐ NO ☐ NOTICED ANY MOUTH ODOR OR BAD TASTES? YES ☐ NO ☐
DO YOU FREQUENTLY GET COLD SORES, BLISTERS OR ANY OTHER LESIONS? YES ☐ NO ☐

DO YOUR GUMS HURT OR BLEED? YES ☐ NO ☐ HAVE YOUR PARENTS EXPERIENCED GUM DISEASE OR TOOTH LOSS? YES ☐ NO ☐
HAVE YOU NOTICED ANY LOOSE TEETH OR CHANGE IN YOUR BITE? YES ☐ NO ☐
DOES FOOD BECOME CAUGHT BETWEEN YOUR TEETH? YES ☐ NO ☐ WHERE?

DO YOU: CLENCH OR GRIND YOUR TEETH WHILE AWAKE OR ASLEEP? YES ☐ NO ☐ HAVE TIRED JAWS, ESPECIALLY IN THE MORNING? YES ☐ NO ☐
CHEW OR SMOKE TOBACCO ? YES ☐ NO ☐ HAVE CLICKING OR POPPING OF THE JAW? YES ☐ NO ☐ JAW OR JOINT PAIN? YES ☐ NO ☐

HAVE YOU EVER HAD:
ORTHODONTIC TREATMENT YES ☐ NO ☐ PERIODONTAL TREATMENT? YES ☐ NO ☐
A BITE PLATE OR MOUTH GUARD? YES ☐ NO ☐ A SERIOUS INJURY TO MOUTH OR HEAD? YES ☐ NO ☐
IF SO, PLEASE DESCRIBE, INCLUDING CAUSE.

DO YOU FEEL NERVOUS ABOUT YOUR DENTAL TREATMENT? YES ☐ NO ☐
IF SO, WHAT IS YOUR GREATEST CONCERN?

IS THERE ANYTHING ELSE ABOUT HAVING DENTAL TREATMENT THAT YOU WOULD LIKE US TO KNOW?

continue on other side

Patient Information - Medical History

HAVE YOU BEEN UNDER THE CARE OF A MEDICAL DOCTOR DURING THE PAST TWO YEARS? YES ☐ NO ☐ IF YES, FOR WHAT?

PHYSICIAN'S NAME PHONE NUMBER

ARE YOU CURRENTLY TAKING ANY MEDICATIONS, PILLS OR DRUGS? YES ☐ NO ☐ IF YES, PLEASE LIST EACH ONE

ARE YOU AWARE OF HAVING AN ALLERGIC (OR ADVERSE REACTION) TO ANY MEDICATION OR SUBSTANCE YES ☐ NO ☐ IF YES, PLEASE LIST EACH ONE

PLEASE INDICATE WHICH OF THE FOLLOWING YOU HAVE HAD OR HAVE AT PRESENT. (MARK YES OR NO FOR EACH AND EVERY ITEM ON THE LIST)

HEART (SURGERY, DISEASE, ATTACK)	Y ☐	N ☐	ULCERS	Y ☐	N ☐	HEPATITIS A (INFECTIOUS) B (SERUM)	Y ☐	N ☐
CHEST PAIN	Y ☐	N ☐	DIABETES	Y ☐	N ☐	A.I.D.S.	Y ☐	N ☐
CONGENITAL HEART DISEASE	Y ☐	N ☐	THYROID PROBLEMS	Y ☐	N ☐	H.I.V. POSITIVE	Y ☐	N ☐
HEART MURMUR	Y ☐	N ☐	GLAUCOMA	Y ☐	N ☐	BLOOD TRANSFUSION	Y ☐	N ☐
HIGH BLOOD PRESSURE	Y ☐	N ☐	EMPHYSEMA	Y ☐	N ☐	HEMOPHILIA	Y ☐	N ☐
MITRAL VALVE PROLAPSE	Y ☐	N ☐	CHRONIC COUGH	Y ☐	N ☐	SICKLE CELL DISEASE	Y ☐	N ☐
HEART PACEMAKER	Y ☐	N ☐	TUBERCULOSIS	Y ☐	N ☐	BRUISE EASILY	Y ☐	N ☐
RHEUMATIC FEVER	Y ☐	N ☐	ASTHMA	Y ☐	N ☐	LIVER DISEASE	Y ☐	N ☐
ARTHRITIS/RHEUMATISM	Y ☐	N ☐	LATEX SENSITIVITY	Y ☐	N ☐	YELLOW JAUNDICE	Y ☐	N ☐
STROKE	Y ☐	N ☐	SINUS TROUBLE	Y ☐	N ☐	NEUROLOGICAL DISORDERS	Y ☐	N ☐
DIET (SPECIAL/RESTRICTED)	Y ☐	N ☐	RADIATION THERAPY	Y ☐	N ☐	EPILEPSY OR SEIZURES	Y ☐	N ☐
ARTIFICIAL JOINTS (HIP, KNEE, ETC.)	Y ☐	N ☐	CHEMOTHERAPY	Y ☐	N ☐	FAINTING OR DIZZY SPELLS	Y ☐	N ☐
KIDNEY TROUBLE	Y ☐	N ☐	TUMORS	Y ☐	N ☐	NERVOUS/ANXIOUS	Y ☐	N ☐
PSYCHIATRIC/PSYCHOLOGICAL CARE	Y ☐	N ☐	ANY DISEASE, CONDITION OR MEDICAL PROBLEM NOT LISTED?				Y ☐	N ☐

IF YOU HAVE ANY DISEASE, CONDITION OR MEDICAL PROBLEM NOT FOUND ON THE ABOVE LIST, PLEASE PROVIDE DETAILS HERE

WOMEN: ARE YOU PREGNANT Y ☐ N ☐ NUMBER OF MONTHS NURSING Y ☐ N ☐ TAKING BIRTH CONTROL PILLS Y ☐ N ☐

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should any further information be needed, you have my permission to ask the respective health care provider or agency, who may release the information to you. I will notify the doctor of any change in my health or medication.

PATIENT/GUARDIAN SIGNATURE_____ DATE_____

HISTORY REVIEW

DENTIST'S SIGNATURE_____ DATE_____

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