

**Surname:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nationality: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Languages:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Dental Insurance Company and Policy Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Limit per year (if known):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Children (under 18yrs) - Dutch Insurance Policy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Dental Hygiene**

**How often do you brush your teeth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you use any of the following: dental floss - tooth picks - interdental brushes – other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Type of toothbrush: Manual Electric**

**Today’s visit is for a consultation (Intake) and X-rays - please list any dental issues you would like to discuss with the dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Last dental appointment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Country:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Last X-rays:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ List if known: – Bitewings - PA/Solo - Panoramic/OPT.**

**(Please email previous X-rays and dental records to ihchdental@ezorg.nl to be placed in your file)**

**Health History**

**Use of tobacco products: YES / NO Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Alcoholic intake: YES / NO Frequency/Units per day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Currently under medical treatment: YES / NO Please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you taking any medication, including non-prescription medicine? YES / NO**

**Please list medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you allergic to any of the following? YES / NO**

⃝ Aspirin ⃝ Penicillin ⃝ Local Anesthetics ⃝ Any metal ⃝ Latex

⃝ Other If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you clench or grind your teeth? ⃝ Yes ⃝ No**

**Do your gums bleed while brushing or flossing? ⃝ Yes ⃝ No**

**Do you have any broken tooth? ⃝ Yes ⃝ No**

**Are your teeth sensitive to hot or cold liquids/food? ⃝ Yes ⃝ No**

**Are your teeth sensitive to sweet or sour liquids/food? ⃝ Yes ⃝ No**

**Do you feel pain to any of your teeth? ⃝ Yes ⃝ No**

If yes, please explain where/which kind of pain**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you experienced any of the following problems in your jaw?**

 **Clicking ⃝ Yes ⃝ No**

 **Pain (joint, ear, side of face) ⃝ Yes ⃝ No**

 **Difficulty opening or closing ⃝ Yes ⃝ No**

 **Difficulty in chewing ⃝ Yes ⃝ No**

**Do you have frequent headaches? ⃝ Yes ⃝ No**

**Have you ever had any difficult extractions in the past? ⃝ Yes ⃝ No**

**Have you ever had any prolonged bleeding following extractions? ⃝ Yes ⃝ No**

**Do you wear dentures, dental prosthesis or an ortho appliance? ⃝ Yes ⃝ No**

**Have you ever received oral hygiene instructions regarding the care of your teeth and gums? ⃝ Yes ⃝ No**

**MRA: Mandibular Repositioning Appliance**

**Do you wear an oral appliance at night for snoring or for sleep apnea? ⃝ Yes ⃝ No**

***(Please mention to your dentist if you would like to receive more information about what we can offer for these problems)***

**Please indicate if you have ever had any of the following conditions:**

**⃝ High Blood Pressure ⃝ Heart Disease ⃝ Liver disease**

**⃝ Heart Attack ⃝ Anaemia ⃝ Glaucoma**

**⃝ Rheumatic Fever ⃝ Frequently Tired ⃝ Respiratory Problems**

**⃝ Fainting/Seizures ⃝ Cancer ⃝ Other**

**⃝ Asthma ⃝ Arthritis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**⃝ Low Blood Pressure ⃝ Joint Replacement/ Implant \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**⃝ Epilepsy/Convulsions ⃝ Hepatitis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**⃝ Leukaemia ⃝ Sexually Transmitted Disease**

**⃝ Diabetes ⃝ Digestive Disorders**

**⃝ Kidney Disease ⃝ Chest Pains**

**⃝ AIDS/HIV Infection ⃝ Stroke**

**⃝ Thyroid Problems ⃝ Tuberculosis**

**Female Patients**

**Are you pregnant or think you may be pregnant? ⃝ Yes ⃝ No Are you breast feeding? ⃝ Yes ⃝ No**

***I have answered the questions to the best of my knowledge. I understand that withholding pertinent information may affect a full diagnosis. It is my responsibility to inform the dental office of any changes in my medical status. I give permission for the IHCH Dental Clinic to record my personal data and health history until further notice.***

***I understand that if I miss an appointment or decide to cancel with less than 24hrs notice, I will be charged a fee***

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Patient, Parent or Guardian Date**