Halonen family dentistry

Rodney Halonen, DDS • Susan Halonen, DDS • Todd Halonen, DDS

Date: _____

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name Last	First	Middle	Email	
Address	City		State	Zip
Home Phone (Please √ preferred contact #) ☐	Cell Phone ☐	Work Phone ☐		
SS# / State ID	Occupation	Date of Birth	Height	Weight	Sex
Emergency Contact	Relationship	Home Phone	Cell Phone	

Dental Information

Please mark (X) your responses to the following questions. Check **DK** If you **D**on't **K**now the answer.

	Y	N	DK	TMJ (Jaw Joint)	Y	N	DK
Are you currently experiencing dental pain or discomfort?	☐	☐	☐	Do you have earaches or neck pains?	☐	☐	☐
				Do you clech or grind your teeth?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐	Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐	Do you wear, or have you ever worn, a nighttime bitesplint?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐		Date of your last dental exam: What was done at that time?			
Is your mouth dry?	☐	☐	☐	Date of last dental x-rays:			
Is your home on well water?	☐	☐	☐				
Have you had any problems associated with previous dental treatment?	☐	☐	☐	Do you prefer appointment reminders by…(mark all that apply)			
Do you wear dentures or partials?	☐	☐	☐	☐ Mail, ☐ Phone, ☐ Text Message, ☐ Email			
Have you ever had a serious injury or surgery to your head or mouth?	☐	☐		How did you hear about our office?			

What is the reason for you dental visit today?

How do you feel about your oral health and appearance?

Medical Information

	Y	N	DK		Y	N	DK
Are you now under the care of a physician?	☐	☐	☐	Have you had a serious illness, operation or been hospitalized in the past 5 years?.....	☐	☐	☐
Physician Name:	Phone			If yes, what was the illness or problem?			
Address/City/State/Zip				Date of Last Physical Exam?			

Please list all the prescription/OTC/ diet supplements you are taking **AND** the reason you are taking them.

_____

_____

_____

_____

_____

Medical Information

	Y	N	DK
Do you use tobacco?	☐	☐	☐
How Long? _____ How much? _____			
If so, are you interested in quitting?	☐	☐	☐
Do you drink alcoholic beverages?	☐	☐	☐
How many drinks do you consumer per week?			
Do you use illegal or recreational drugs	☐	☐	☐
Are you taking, or have you taken, any diet drugs such as Pondimin (fenflluramine), Redux (dexphenfluramine) or phen-fen (fenflluramine-phentermine combination)?.....	☐	☐	☐

	Y	N	DK
Were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia~ or Zometa"') for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?.....	☐	☐	☐
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax~) or risedronate (Actonel~) for osteoporosis or Paget's disease? ……	☐	☐	☐

Joint Replacement – Have you had an orthopedic total joint (hip, knee, elbow) replacement?..... ☐ ☐ ☐
Which joint? _____ Date: _____. Have you had any complications?..... ☐ ☐ ☐

Allergies – Are you allergic to or have you had a reaction to:

	Y	N	DK		Y	N	DK
Penicillin	☐	☐	☐	Sulfa Drugs	☐	☐	☐
Erythromycin	☐	☐	☐	Codeine	☐	☐	☐
Local Anesthetic	☐	☐	☐	Seasonal	☐	☐	☐
Latex / Food	☐	☐	☐	Other:			

Please Explain:

Women Only - Are you:

Pregnant?	☐	☐	☐
Number of Weeks? _____			
Nursing?	☐	☐	
Taking birth control pills or hormonal replacement?	☐	☐	☐

Do you currently have or ever had a history of the following?

	Y	N	DK		Y	N	DK		Y	N	DK		Y	N	DK
Heart murmur	☐	☐	☐	Asthma	☐	☐	☐	Acid Reflux	☐	☐	☐	Autoimmune disease	☐	☐	☐
Rheumatic fever	☐	☐	☐	Bronchitis	☐	☐	☐	Ulcers	☐	☐	☐	Arthritis	☐	☐	☐
Artificial heart valves	☐	☐	☐	Emphysema	☐	☐	☐	Hepatitis	☐	☐	☐	Lupus	☐	☐	☐
High Blood Pressure	☐	☐	☐	Tuberculosis	☐	☐	☐	Liver Disease	☐	☐	☐	Migraines	☐	☐	☐
Heart attack	☐	☐	☐	Thyroid problem	☐	☐	☐	Kidney Infections	☐	☐	☐	Sleep Disorder	☐	☐	☐
Pacemaker	☐	☐	☐	Diabetes	☐	☐	☐	Kidney Disease	☐	☐	☐	Sleep with CPAP	☐	☐	☐
Congestive heart failure	☐	☐	☐	Eating disorder	☐	☐	☐	Anemia	☐	☐	☐	AIDS or HIV	☐	☐	☐
Chest Pain	☐	☐	☐	Depression	☐	☐	☐	Abnormal Bleeding	☐	☐	☐	STD	☐	☐	☐
Stroke	☐	☐	☐	Anxiety	☐	☐	☐	Clotting Disorder/DVT	☐	☐	☐	Cancer	☐	☐	☐
Fainting spells	☐	☐	☐	Other Mental Health	☐	☐	☐	Seizures	☐	☐	☐	Radiation Therapy	☐	☐	☐

Do you have any disease, condition, or problem not listed above that may be important to you health? Please explain.

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truth health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for a action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/ Legal Guardian: Date:

For Completion by Dental Examiner

Comments: _____

_____

_____

Has patient ever been premedicated and why? _____

_____