HORNBROOK
CENTER FOR DENTISTRY

HORNBROOK.COM
info@Hornbrook.com
619-463-7797
f. 619-463-1351
7777 Alvarado Road Suite 210 La Mesa California 91942

PATIENT INFORMATION

Date: _____ / _____ / _____

The benefits of a healthy, beautiful smile are immeasurable. Our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve. The information on these forms is confidential and will enable us to provide you the very best care possible.

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss

First Name_____ MI_____ Last Name_____

I prefer to be called_____ Birthdate ____/____/____ SS#_____

Home address_____ City _____ Zip _____

How May We Contact You?

Home: ( )_____ Work: ( )_____

Mobile:( )_____ E-Mail:_____

Where do you prefer to receive calls? ☐ Home ☐ Work ☐ Mobile

When is the best time to reach you? Time:_____

Special interests or hobbies?_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow(er)

Spouse's name_____

Your occupation_____ Employer _____

In case of emergency is there someone we can call ?

Name _____ Ph # _____

Relation to patient_____

Do you have dental insurance? ☐ Yes ☐ No If Yes, which insurance carrier?_____

Insured member's name _____ DOB _____ / _____ / _____ SS#_____

Employer _____

Relationship to insured_____ Employer Policy or Group# _____

Address of the insured: _____

City: _____ State: _____ Zip: _____

Insurance company address: _____

City: _____ State: _____ Zip: _____

Phone: ( ) _____

Do you have secondary insurance coverage? _____

How did you hear about our practice? ☐ Our Website ☐ Radio/TV ☐ Print Media ☐ Personal Referral

Personal Referral: If so, whom may we thank?_____

HORNBROOK
CENTER FOR DENTISTRY

HORNBROOK.COM
info@Hornbrook.com
619-463-7797
f. 619-463-1351
7777 Alvarado Road Suite 210 La Mesa California 91942

HEALTH HISTORY

Name of personal physician_____ Phone #:_____
How do you assess your current health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Are you currently under the care of a physician? ☐ Yes ☐ No
If yes, please explain: _____
Have you been hospitalized or had any serious medical problems within the past 5 years? ☐ Yes ☐ No
If yes, please explain:_____

☐ Angina (chest pains) Frequency_____
☐ Heart attack (date) _____
☐ Heart surgery (date) _____
☐ Pacemaker
☐ Bypass
☐ Rheumatic Fever (date) _____
☐ Heart murmur/ mitral valve prolapse
☐ High blood pressure
☐ Stroke (date): _____
☐ Prosthetic heart valve
☐ Other_____

Have you ever had or been treated for any of the following diseases or medical conditions? (please check all that apply)

☐ Hepatitis/Jaundice
☐ Epilepsy/Seizures/Fainting
☐ Cancer/Chemotherapy
☐ Psychiatric problems
☐ Tuberculosis
☐ AIDS/HIV
☐ Drug/Alcohol abuse
☐ Ulcers
☐ Abnormal bleeding
☐ Kidney problems
☐ Diabetes
☐ Asthma or lung disease
☐ Hip or other joint replacement
☐ Anemia
☐ Arthritis
☐ Glaucoma

Have you been treated for any other illnesses not listed above? ☐ Yes ☐ No If yes, please explain:

_____

Are you allergic to any of the following medications? (please check all that apply)

☐ Penicillin
☐ Erythromycin
☐ Codeine
☐ Dental Anesthetic
☐ Latex
☐ Aspirin

Are you allergic to any other pain medications or antibiotics? ☐ Yes ☐ No If yes, please list:

_____

Have you ever been advised to take antibiotics before dental treatment? ☐ Yes ☐ No
Are you currently taking prescription medications? (If yes, please list below) ☐ Yes ☐ No
Name of Medication Purpose

_____

_____

Women: Are you pregnant? ☐ Yes ☐ No (Expected delivery date _____)
Women: Are you taking birth control pills ☐ Yes ☐ No
(Certain antibiotics may adversely interact with oral contraceptives)

HORNBROOK
CENTER FOR DENTISTRY

HORNBROOK.COM
info@Hornbrook.com
619-463-7797
f. 619-463-1351
7777 Alvarado Road Suite 210 La Mesa California 91942

DENTAL HISTORY

If you could wave a magic wand and change anything you could about the appearance of your smile, what would you do?

_____

_____

The date of your last dental visit _____ Previous dentists name _____

Have you ever had a less than positive dental experience? ☐ Yes ☐ No If so, please explain _____

_____

_____

Why have you come to the dentist today? _____

_____

If you could easily and safely whiten your teeth, would you be interested? ☐ Yes ☐ No

Are you currently in pain or discomfort with your teeth or gums? _____

Have you ever had:

☐ Orthodontic treatment?
If yes, when? _____
☐ Oral surgery?
If yes, when? _____
☐ Periodontal surgery?
If yes, when? _____
☐ Your bite adjusted?
If yes, when? _____
☐ A mouth or night guard?

☐ Do your gums bleed or hurt?
If yes, where? _____
☐ Have your parents experienced gum disease or tooth loss?
☐ Have you noticed any loose teeth or change in your bite?
If yes, where? _____
☐ Does food get caught between your teeth?
If yes, where? _____

Are any of your teeth sensitive to:

☐ Hot or cold
☐ Biting or chewing

Do you:

☐ Clench or grind your teeth while awake or asleep?
☐ Bite your lips or cheeks regularly?
☐ Mouth breathe while awake or asleep?
☐ Have tired jaws, especially in the morning?
☐ Smoke or chew tobacco?
How often? _____
☐ Feel nervous about having dental treatment

Have you experienced:

☐ Clicking or popping of the jaw?
☐ Pain? (joint, ear, side of face)
☐ Difficulty in opening or closing your mouth?
☐ Difficulty in chewing on either side of your mouth?
☐ Headaches or neck pain?

How often do you brush your teeth? _____
How often do you floss? _____
What other dental aids do you use? (Sonicare, Water-Pik, toothpicks, etc.) _____

_____

☐ Have you noticed mouth odors or bad tastes?
☐ Do you frequently get cold sores, blisters or any other oral lesions?

I understand that the information is correct to the best of my knowledge. I understand it will be held in the strictest confidence and only be used to improve communication between Dr. Hornbrook or his Associates and myself. I also give permission for Dr. Hornbrook or his Associates to use any photos they may take to be used for lecturing or education purposes.

Signature _____ Date _____