Hank Barreto D.M.D.
Francine Misch-Dietsh, D.D.S.
135 San Lorenzo Ave.
Coral Gables, FL 33146

PATIENT HEALTH RECORD

Date:________________
Name:___________________________________Spouse's Name:____
Address:____City:_______________ State:_____ Zip:________________
Home Phone:____________________ Business Phone:_____________________ Cel: __________________________
Email: ____
Date of Birth:____________________ Sex:__________ Height: ______________ Weight:_______________________
Occupation: _______________________ Social Security #: ______________________ Single _____ Married ______
In case of Emergency notify: _________________________________ Phone: ______________________________
Whom may we thank for referring you to us? ____

MEDICAL HEALTH

Name and address of physician: ____
Have you been under a physician's care during the past 2 years?______ For? _____________________________
Have you been treated in a hospital in the past 2 years? ______ For? _____________________________________
If female; are you taking hormones or birth control pills? ___________ Are you pregnant or nursing? _________
Have you ever had a blood test for hepatitis? ___________________ Were you vaccinated? _______________
Have you had cankers or cold sores on your lips, tongue, gums or body? _________________________________
Do you require premedication before dental appointments? _________ Prescription: ______________________
Are you allergic to: ☐ Penicillin ☐Codeine ☐Sulfa Drugs ☐ Local Anesthetics ☐Other: ____________________
What medications are you taking? ☐Nerve Pills ☐Pain Killers ☐Muscle Relaxers ☐Stimulants ☐Blood Thinners
☐Tranquilizers ☐Insulin ☐Meds for Osteoporosis ☐Other(s) Please List:____________________________________

HAVE YOU HAD OR DO YOU NOW HAVE:

	YES	NO		YES	NO
Abnormal Blood Pressure	☐	☐	Frequent Headaches	☐	☐
AIDS	☐	☐	Hepatitis	☐	☐
Allergies	☐	☐	Herpes	☐	☐
Anemia	☐	☐	Jaundice	☐	☐
Angina	☐	☐	Kidney disease	☐	☐
Arthritis	☐	☐	Liver disease	☐	☐
Artificial heart valves	☐	☐	Organ transplant	☐	☐
Artificial joints	☐	☐	Pacemaker	☐	☐
Asthma	☐	☐	Polio	☐	☐
Cancer	☐	☐	Prolonged bleeding	☐	☐
Chemotherapy	☐	☐	Prolonged cough	☐	☐
Congenital Heart Lesions	☐	☐	Psychiatric treatment	☐	☐
Diabetes	☐	☐	Radiation Therapy	☐	☐
Drug Dependency	☐	☐	Rheumatic Fever	☐	☐
Epilepsy	☐	☐	Sexually transmitted disease	☐	☐
Fainting	☐	☐	Sickle Cell Anemia	☐	☐
Glaucoma	☐	☐	Sinus problem	☐	☐
Heart Disease	☐	☐	Stroke	☐	☐
Heart Murmur/Mitral Valve	☐	☐	Thyroid disease	☐	☐
Easily Exhausted or fatigued	☐	☐	Tuberculosis	☐	☐
Slow Healing	☐	☐	Ulcers	☐	☐

Have you any disease, condition, or problem not previously listed?____

When was your last dental visit?____

How often did you see your dentist? ____

Are you having any dental problems that require immediate attention? ___________________________________

Do any of the following cause tooth discomfort? Hot _______ Cold _______ Sweets _______ Chewing ________

How often do your brush your teeth? ______________ Floss?_________________ Water Jet? ____________________

Do your gums bleed?____

Do your gums ever feel tender or swollen? ____

Have you had periodontal treatment? __________ When? ____

Do you clench or grind your teeth? ____

Do your jaws ever feel tired or ache? ____________________ Click or pop? _________________________________

Can you chew on both sides of your mouth? ______________ Comfortably? ________________________________

Do you search for a place to close your teeth? ____

Do you have frequent headaches? ____________________ Earaches? ____________________________________

Do you have tightness, tiredness, in the head, neck or throat? ____

Have you ever had orthodontic treatment (braces)? ___________ When? ___________________________________

Do you lose fillings or break fillings? ____

Do you usually have many cavities? ____

Do you have any loose teeth? __________________ Cracked or broken teeth? ______________________________

Do you have any noticeable wear on your teeth? _____________Food Trap? _______________________________

Do you have any missing teeth? __________________ Have they been replaced? ____________________________

If so, how? Fixed bridge _______ Removable partial _______ Full Denture _______ Dental Implants ________

Are you comfortable with the replacement? ________ Please describe ____________________________________

How do you feel about the appearance of your smile? ____

Have you ever had any cosmetic dentistry done to improve your appearance? ___________________________

If yes, are you pleased with the result? ________ Please comment _____________________________________

Have you ever had an unpleasant dental experience? ____

Do you have bitter or metallic taste in your mouth? ____

Please add anything you feel is important ____

• I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

SIGNATURE: ____

DOCTORS SIGNATURE:____