DENTAL COMMUNITY HEALTH
MEDICAL • DENTAL • BEHAVIORAL HEALTH

RUTLAND | 69 Allen Street, Suite 10, Rutland, VT 05701 | 802-774-5050
KIDS | 69 Allen Street, Suite 7, Rutland, VT 05701 | 802-772-4413
SHOREWELL | 2987 VT Route 22A, Shoreham, VT 05770 | 802-897-7716
CHCRR.org

HEALTH INFORMATION

NAME (print):_____ DOB: _____

FORMER NAME: _____ PHONE: _____

ADDRESS: _____ CITY/STATE: _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING? PLEASE CHECK THOSE THAT APPLY:

- ☐ ADHD/ADD
- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Artificial Heart Valves
- ☐ Asthma
- ☐ Blood Disease
- ☐ Breastfeeding ☐
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes Type __
- ☐ Dizziness
- ☐ Ear Tubes
- ☐ Epilepsy ☐
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths/Tumors
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis Type: __
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ HPV
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Neurological Disorder
- ☐ Pacemaker
- ☐ Pregnant
  Due Date _____
- ☐ Radiation Treatment
- ☐ Recreational Drugs
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Smoking
- ☐ Vaping
- ☐ Chew Tobacco
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Thyroid problems

Allergies

- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Latex Allergy
- ☐ Nickel Allergy
- ☐ Local Anesthetic
- ☐ Sulfa Drugs
- ☐ Aspirin (NSAIDs)

Other Allergies

- ☐ _____
- ☐ _____

Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain _____

Are you taking any medications? ☐ Yes ☐ No
If yes, please list _____

Have you been admitted to a hospital or needed emergency care during the past two years ☐ Yes ☐ No
If yes, please explain _____

Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain _____

DENTAL INFORMATION

Date of Last Dental Visit _____ Date of X-Rays _____ Reason for Visit _____

How often do you brush your teeth? _____ How often do you floss? _____

Do your gums bleed while brushing? ☐ Yes ☐ No
Do heat, cold, sweets or pressure cause you pain in your mouth? ☐ Yes ☐ No
Do you have clicking, popping or discomfort in your jaw? ☐ Yes ☐ No
Have you ever been instructed in the home care of your mouth? ☐ Yes ☐ No
Have you ever had any complications following dental treatment? ☐ Yes ☐ No

To the best of my knowledge, all of the above answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at my next appointment.

Print Name of Patient	Signature of Patient, or if minor, as applicable, Parent/Guardian/Loco Parentis	Date

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