Patient Health Record

In order to help us render the proper dental services to you, would you please be kind enough to answer the following questions.

If this appointment is for you start here

Date _____
Name _____
Address _____
_____
Home Phone # _____
Cell Phone # _____
Best # to Call _____
Email Address _____
_____
Birthdate _____
❑ Married ❑ Single ❑ Divorced ❑ Widowed

If this appointment is for your child start here

Date _____
Name _____
Address _____
_____
Home Phone # _____
Birthdate _____ Age _____
Grade _____
School _____
If your child's address is different from yours, please fill in the top box also.

Primary Dental Insurance

Insurance Co. Name: _____
Insurance Co. Address: _____
_____
Insurance Co Phone #: _____
Insurance ID #: _____
Insurance Group # _____
Insured's Name: _____ Relation: _____
Insured's Birthday: __/__/__ Insured's SS#: _____
Insured's Employer: _____

Secondary Dental Insurance

Insurance Co. Name: _____
Insurance Co. Address: _____
_____
Insurance Co. Phone #: _____
Insurance ID #: _____
Insurance Group #: _____
Insured's Name: _____ Relation: _____
Insured's Birthday: __/__/__ Insured's SS#: _____
Insured's Employer: _____

Account Information

Person Responsible for Account _____
Occupation _____
Employer _____
Employer Phone # _____
Driver's License # _____
Bank _____
Your Spouse _____
Spouse's Employer _____
Spouse's Employer Phone # _____

Getting to know you

What are your hobbies and interests? _____
_____
Where were you raised? _____
Number of children? _____
Are any of your relatives a patient of our office? _____
Referred to us by _____
Person to contact for emergency _____
Phone _____
How do you wish to be addressed by our staff? _____

Please fill out the Medical History on the other side.

Dental History

Reason for today's visit _____ Date last Dental visit _____ What was done then? _____
How often do you brush your teeth? _____ Floss? _____ What texture brush do you use? _____
Previous Dentist? _____ Reason for leaving dentist? _____

Do any of the following conditions apply to you? (circle yes or no)

Bleeding gums?	yes	no	Teeth straightened?	yes	no	Do your teeth hurt when in contact with:		
Food impaction?	yes	no	Sounds in ears when chewing?	yes	no	Hot foods or liquids?	yes	no
Swelling or lump in mouth?	yes	no	Loose teeth?	yes	no	Cold food or liquids?	yes	no
Clenching or grinding teeth?	yes	no	Avoid Brushing any			Sweet foods or liquids?	yes	no
Unpleasant taste?	yes	no	area of your mouth?	yes	no	Are you satisfied with the		
Tired Jaws?	yes	no	What area? _____			appearance of your teeth?	yes	no
Gag easily?	yes	no	I would like my teeth whiter	yes	no	Any serious prolems with		
Complications from extractions?	yes	no	I prefer tooth colored fillings	yes	no	dental treatment?	yes	no
Gum Treatments?	yes	no	Use Fluoride supplements?	yes	no	Do you have any mouth pain?	yes	no

Please answer the following general health questions.

1. Are you in good health? ..... yes no
2. Date of your last physical exam _____
3. Are you now under the care of a physician? ..... yes no
   Physician's name _____ Phone #_____
4. Have you been hospitalized or had a serious illness within the past 5 years? ..... yes no
5. Are you now taking any medications? ..... yes no
   If yes, please list those medications _____
6. Do you take any herbal medications or vitamins? ..... yes no
   If yes, please list those medications _____
7. Are you allergic or have you reacted adversely to any of the following medications? (Please circle if yes)

Aspirin	Vicodin	Novocaine or Lidocaine	Penicillin
Tylenol	Demerol	Valium	Tetracycline
Local Anesthetic	Percodan	Sleeping Pills	Erythromycin
Nitrous Oxide	Darvon	Codeine	Sulpha

8. Please list any other medication or substance to which you are allergic _____
9. Have you ever had: (Please circle if yes)

Anemia	Convulsions	Heart Trouble	Rheumatic Fever
Angina Pectoris	Diabetes	Hepatitis or liver disease	Stroke
Arthritis	Epilepsy	High Blood Pressure	Tuberculosis
Artificial joint	Glaucoma	Jaundice	Tumor or growth
Asthma	Heart Attack	Kidney Disease	Ulcers
Bleeding problems	Heart Murmur	Latex Allergies	Venereal Disease
Blood transfusion	Heart Pacemaker	Positive test for AIDS virus	Other_____
Chemotherapy			

10. Do you get up often at night to urinate? ..... yes no
11. Are you thirsty much of the time? ..... yes no
12. Has anyone in your family had diabetes? ..... yes no
13. Do you consider yourself a nervous person? ..... yes no
14. Do you smoke? ..... yes no
    If yes, how much?_____
    Do you use spit tobacco? ..... yes no
15. Do you have any disease, condition or problem not listed above that you think we should know about? ..... yes no
16. Are you on a special diet? ..... yes no

For Women only: Are you pregnant? ..... yes no
If yes, what month? _____ Due date: _____
Are you practicing birth control? ..... yes no

CONSENT: The undersigned hereby authorizes Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient)_____ and further authorize and consent that Doctor choose and employ such assistance as he/she deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. If necessary, payment plans may be arranged. To the best of my knowledge, I have provided information which is true and correct. If I ever have any change in my health, or if my medications change, I will inform the doctor at the next appointment without fail.

Signature _____ Date _____

Signature _____ Date _____

NOTES