PATIENT HEALTH RECORD

Date _____

Name _____ Spouse's Name _____
(last) (first) (initial)

Address _____

Home Phone _____ Business Phone _____

Date of Birth _____ Sex _____ Height _____ Weight _____

Occupation _____ Social Security No. ___-___-___ Single _____ Married _____

Closest Relative _____ Phone _____

Whom may we thank for referring you to us? _____

Email Address: _____

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 _____

Have you ever had major surgery? _____

If female: Are you taking hormones or birth control?_____ 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? _____

Are you now taking or have you taken any prescription drugs during the past year?_____List _____

_____

Are you allergic to: ☐ Penicillin ☐ Codeine ☐ Local anesthetics ☐ Other _____

Are you taking or have you ever taken any of the following medications (Circle): ACTONEL, FOSAMAX, BONIVA, SKELID, DIDRONEL, AREDIA, ZOMETA, BONEFOS

Have you had or do you now have:

	yes	no		yes	no
Abnormal blood pressure	☐	☐	Hepatitis	☐	☐
AIDS	☐	☐	Herpes	☐	☐
Allergies	☐	☐	Jaundice	☐	☐
Anemia	☐	☐	Kidney disease	☐	☐
Angina	☐	☐	Liver disease	☐	☐
Arthritis	☐	☐	Organ transplant	☐	☐
Artificial heart valves	☐	☐	Pacemaker	☐	☐
Artificial joints	☐	☐	Polio	☐	☐
Asthma	☐	☐	Prolonged bleeding	☐	☐
Cancer	☐	☐	Prolonged cough	☐	☐
Chemotherapy	☐	☐	Psychiatric treatment	☐	☐
Congenital heart lesions	☐	☐	Radiation therapy	☐	☐
Diabetes	☐	☐	Rheumatic fever	☐	☐
Drug dependency	☐	☐	Sickle cell anemia	☐	☐
Epilepsy	☐	☐	Stroke	☐	☐
Fainting	☐	☐	Thyroid disease	☐	☐
Glaucoma	☐	☐	Tuberculosis	☐	☐
Heart disease	☐	☐	Ulcers	☐	☐
Heart murmur	☐	☐	Venereal disease	☐	☐

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

_____

DENTAL HEALTH

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 you brush your teeth? _____ Floss? _____ Water Jet? _____

Do your gums bleed while cleaning? _____

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 have frequent headaches? _____ Earaches? _____

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 traps _____

Do you have any missing teeth? _____ Have they been replaced? _____

If so, how? Fixed bridge _____ Removable partial _____ Full denture _____ Dental implant _____

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? _____

Please add anything you feel is important: _____

_____

_____

_____

_____

_____

Signature _____

PATIENT INFORMATION

NAME _____ HOMEPHONE _____

ADDRESS _____

SEX	M	F	DATE OF BIRTH	MON	DAY	YR	AGE	MARITAL STATUS	S	M	W	D

CELL PHONE _____

EMPLOYER'S NAME _____ OCCUPATION _____

EMPLOYER'S ADDRESS _____ BUSINESS PHONE _____

SOCIAL SECURITY NO. _____

PARTY RESPONSIBLE FOR THIS ACCOUNT

NAME _____ HOME PHONE _____

ADDRESS _____

RELATIONSHIP TO PATIENT _____ SOCIAL SECURITY NO. _____

EMPLOYER'S NAME _____ BUSINESS PHONE _____

EMPLOYER'S ADDRESS _____

INSURANCE CONFIRMATION

1. INSURED PARTY _____ ID NO. _____
   CARRIER _____ POLICY NO. _____
   SEND CLAIMS TO _____ GROUP NO. _____

2. INSURED PARTY _____ ID NO. _____
   CARRIER _____ POLICY NO. _____
   SEND CLAIMS TO _____ GROUP NO. _____

OTHER

PREVIOUS DENTIST'S NAME & ADDRESS _____

PHYSICIAN'S NAME & ADDRESS _____

IN CASE OF EMERGENCY NOTIFY NAME _____

RELATIONSHIP TO PATIENT _____ PHONE NO.(S) _____

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

E-MAIL ADDRESS _____