

PATIENT HEALTH RECORD

Please Print

REFERRED BY _____

DATE _____ DENTIST'S PHONE _____

NAME _____ AGE _____ BIRTH DATE _____

SEX _____ MARITAL STATUS _____ SOCIAL SECURITY NO. _____ HOME PHONE _____

HOME ADDRESS _____ CELL PHONE _____

Street City State Zip

PLACE OF EMPLOYMENT _____ OCCUPATION _____

ADDRESS _____ PHONE _____

Street City State Zip

DO YOU HAVE DENTAL INSURANCE _____ YES/NO _____ COMPANY _____

POLICY NO. _____ GROUP/AGREEMENT NO. _____

IF SPOUSE ALSO HAS INSURANCE - COMPLETE THE NEXT SECTION. (PARENT PLEASE COMPLETE IF PATIENT IS A MINOR)

SPOUSE: NAME _____ SOCIAL SECURITY NO. _____

PLACE OF EMPLOYMENT _____ DATE OF BIRTH _____

DOES SPOUSE/PARENT HAVE DENTAL INS.: ___ Y ___ N INS. CO. _____

POLICY NO. _____ GROUP/AGREEMENT NO. _____

PHYSICIAN _____ PHONE _____

Name Address

CHECK () EITHER "YES" OR "NO"

- | | | | | | |
|---|--------------------------|--------------------------|---------------------------------------|--------------------------|--------------------------|
| 1. Are you presently in pain? | <input type="checkbox"/> | <input type="checkbox"/> | YES | NO | |
| 2. Are you under medical treatment now? | <input type="checkbox"/> | <input type="checkbox"/> | YES | NO | |
| 3. Are you taking any medication now? | <input type="checkbox"/> | <input type="checkbox"/> | YES | NO | |
| What? _____ For what purpose? _____ | | | | | |
| 4. Have you been told to premedicate prior to dental visits? | <input type="checkbox"/> | <input type="checkbox"/> | YES | NO | |
| What antibiotics do you take? _____ For what purpose? _____ | | | | | |
| 5. Are you allergic to any antibiotics, local anesthetics or had an adverse reaction to any other drug? | <input type="checkbox"/> | <input type="checkbox"/> | YES | NO | |
| Please list: _____ | | | | | |
| 6. Have you ever been hospitalized? | <input type="checkbox"/> | <input type="checkbox"/> | YES | NO | |
| For what? _____ | | | | | |
| 7. Have you ever been treated for: | | | | | |
| | YES | NO | YES | NO | |
| AIDS/HIV Disease | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease, Hepatitis, Jaundice .. | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Disease / Stroke | <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic Fever / Heart Valve problems .. | <input type="checkbox"/> | <input type="checkbox"/> | Venereal Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> |
| Ulcers | <input type="checkbox"/> | <input type="checkbox"/> | Tumors or Growths | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Lupus or Autoimmune Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | Asthma or Emphysema | <input type="checkbox"/> | <input type="checkbox"/> |
| Mental problems or nervous disorders | <input type="checkbox"/> | <input type="checkbox"/> | Sinus trouble | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney trouble | <input type="checkbox"/> | <input type="checkbox"/> | Artificial Joint Replacement | <input type="checkbox"/> | <input type="checkbox"/> |
| Other | <input type="checkbox"/> | <input type="checkbox"/> | Other | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you often have spells of dizziness or fainting? | <input type="checkbox"/> | <input type="checkbox"/> | YES | NO | |
| 9. Does anyone in your family have diabetes? | <input type="checkbox"/> | <input type="checkbox"/> | YES | NO | |
| Who? _____ | | | | | |
| 10. (Women) Are you pregnant? | <input type="checkbox"/> | <input type="checkbox"/> | YES | NO | |
| 11. Have you ever had a severe bleeding after extraction of teeth? | <input type="checkbox"/> | <input type="checkbox"/> | YES | NO | |
| 12. Do you smoke, chew tobacco, or have other oral habits? | <input type="checkbox"/> | <input type="checkbox"/> | YES | NO | |
| 13. Are you in good health at this time? | <input type="checkbox"/> | <input type="checkbox"/> | YES | NO | |

I consent to treatment as necessary or desirable. I also acknowledge full responsibility for payment for such treatment.

Signed _____

patient, parent or guardian (must be 18 years or older)

Reviewed By: _____