



Patient Health Record

Male Female Single Married Divorced Widowed

Date _____ Name of Person Responsible for this Account _____

Patient's Name _____ Employer of Responsible Party _____

Pronounced _____ Dental Insurance Company _____

Address _____ Group Number _____

City _____ Zip _____ Subscriber Name _____

Home Phone () _____ Subscriber Employer _____

Cell Phone () _____ Subscriber Social Security # _____

Work Phone () _____ Subscriber ID # _____

Social Security # _____ Subscriber Date of Birth _____

Date of Birth _____ Name of Spouse/Guardian _____

Occupation _____ Employer of Spouse/Guardian _____

Referred by _____ Email _____

YOUR DENTAL AND MEDICAL HISTORY ARE IMPORTANT. MANY THINGS HAVE A DIRECT BEARING ON YOUR DENTAL HEALTH. THE INFORMATION YOU PROVIDE IS CONFIDENTIAL AND WILL NOT BE RELEASED WITHOUT PERMISSION.

Medical Health

General Health Excellent Good Fair Poor

Name and Address of Physician _____

Date of Last Complete Physical _____

Are you taking any prescription/over-the-counter drug? _____

If Yes, Please List Each One: _____

Have you Ever Been Treated For:

Abnormal Blood Pressure	yes <input type="checkbox"/>	no <input type="checkbox"/>	Sinus Trouble	yes <input type="checkbox"/>	no <input type="checkbox"/>
Heart Attack	yes <input type="checkbox"/>	no <input type="checkbox"/>	Asthma	yes <input type="checkbox"/>	no <input type="checkbox"/>
Heart Surgery	yes <input type="checkbox"/>	no <input type="checkbox"/>	Surgical Shunts, Plates or Pins.....	yes <input type="checkbox"/>	no <input type="checkbox"/>
Heart Murmur	yes <input type="checkbox"/>	no <input type="checkbox"/>	Artificial Joints or Implant	yes <input type="checkbox"/>	no <input type="checkbox"/>
Congenital Heart Lesions.....	yes <input type="checkbox"/>	no <input type="checkbox"/>	Kidney Disease	yes <input type="checkbox"/>	no <input type="checkbox"/>
Artificial Heart Valve	yes <input type="checkbox"/>	no <input type="checkbox"/>	Thyroid Disease	yes <input type="checkbox"/>	no <input type="checkbox"/>
Heart Pacemaker	yes <input type="checkbox"/>	no <input type="checkbox"/>	Arthritis	yes <input type="checkbox"/>	no <input type="checkbox"/>
Congestive Heart Disease	yes <input type="checkbox"/>	no <input type="checkbox"/>	Liver Disease	yes <input type="checkbox"/>	no <input type="checkbox"/>
Stroke	yes <input type="checkbox"/>	no <input type="checkbox"/>	Hepatitis	yes <input type="checkbox"/>	no <input type="checkbox"/>
Anemia	yes <input type="checkbox"/>	no <input type="checkbox"/>	Drug Addiction.....	yes <input type="checkbox"/>	no <input type="checkbox"/>
Rheumatic Fever	yes <input type="checkbox"/>	no <input type="checkbox"/>	Glaucoma	yes <input type="checkbox"/>	no <input type="checkbox"/>
Diabetes.....	yes <input type="checkbox"/>	no <input type="checkbox"/>	Cancer	yes <input type="checkbox"/>	no <input type="checkbox"/>
Epilepsy.....	yes <input type="checkbox"/>	no <input type="checkbox"/>	Hemophilia.....	yes <input type="checkbox"/>	no <input type="checkbox"/>
Tuberculosis or Lung Disease.....	yes <input type="checkbox"/>	no <input type="checkbox"/>	HIV Positive.....	yes <input type="checkbox"/>	no <input type="checkbox"/>
Ulcers	yes <input type="checkbox"/>	no <input type="checkbox"/>			

Are you currently taking or have you ever taken bisphosphonates, either orally or by I.V.?..... yes no
(examples: Aredia, Zometa, Fosamax, Actonel, Boniva)

Have you ever been treated with radiation therapy?..... yes no

Are you allergic to any of the following drugs? Penicillin Aspirin Erythromycin Latex
 Dental Anesthetics Codeine Tetracycline

Please list any other drugs that you are allergic to: _____



Other physical conditions we should be aware of: _____

Are you subject to prolonged bleeding? yes no

Are you subject to fainting spells? yes no

Do you have excessive urination and/or thirst? yes no

Women

Are you taking birth control pills? yes no

Are you pregnant? yes no

Dental History

Your current dental health is: Good Fair Poor

Do you like your smile? _____

When was your last dental appointment? _____

Are you having discomfort at this time? _____

Have you had any injuries to your mouth, teeth or head? _____

Any complications with extractions? _____

Are your teeth sensitive to heat, cold, sweet or sour? _____

Do you have bleeding gums? _____

Have you ever had gum treatments? _____ If yes, when? _____

Are you aware of any swelling, tenderness or lumps in your mouth? _____

Do you experience any numbness or unusual sensation around lips or tongue? _____

Have you had orthodontic treatment? _____

Do you hear popping, clicking or snapping noises when you chew? _____

Any pain in or around ears? _____

Do you have chronic headaches? _____

How often do you floss your teeth _____

How often and when do you brush your teeth? _____

Have you had any unpleasant dental experiences in the past? _____

Do you desire complete dental treatment for your child? _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform, with my informed consent, any necessary dental services I may need during diagnosis and treatment.

Patient Signature _____ Date _____

Doctor Signature _____ Date _____

Thank you for taking the time to fill this form out completely. It will enable us to help you more effectively.
If you have any questions at any time, please be sure to ask us. We are always happy to help.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.