dental health PROFESSIONALS

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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 ☐	no ☐	Sinus Trouble	yes ☐	no ☐
Heart Attack	yes ☐	no ☐	Asthma	yes ☐	no ☐
Heart Surgery	yes ☐	no ☐	Surgical Shunts, Plates or Pins	yes ☐	no ☐
Heart Murmur	yes ☐	no ☐	Artificial Joints or Implant	yes ☐	no ☐
Congenital Heart Lesions	yes ☐	no ☐	Kidney Disease	yes ☐	no ☐
Artificial Heart Valve	yes ☐	no ☐	Thyroid Disease	yes ☐	no ☐
Heart Pacemaker	yes ☐	no ☐	Arthritis	yes ☐	no ☐
Congestive Heart Disease	yes ☐	no ☐	Liver Disease	yes ☐	no ☐
Stroke	yes ☐	no ☐	Hepatitis	yes ☐	no ☐
Anemia	yes ☐	no ☐	Drug Addiction	yes ☐	no ☐
Rheumatic Fever	yes ☐	no ☐	Glaucoma	yes ☐	no ☐
Diabetes	yes ☐	no ☐	Cancer	yes ☐	no ☐
Epilepsy	yes ☐	no ☐	Hemophilia	yes ☐	no ☐
Tuberculosis or Lung Disease	yes ☐	no ☐	HIV Positive	yes ☐	no ☐
Ulcers	yes ☐	no ☐			

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.

I hereby certify that I have reviewed the medical history on the following date and have informed the doctor or a staff member of any changes that have occurred since my last review. I will not hold them responsible for any errors or omissions that I have made in completion of this form.

Date	Changes since last visit	Patient Signature	Provider Signature