Patient Health Record

The following information is required to assist the Doctor in administering the proper dental service.

Please answer the questions to the best of your ability. Thank you for your cooperation.

NAME (Last)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(First)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Middle)\_\_\_\_\_\_\_\_\_\_\_

HOME ADDRESS (Apt.) (City) (Zip)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BUSINESS ADDRESS (City) (Zip)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE (Home) (Business) (Beeper or Cell Phone)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF

BIRTH SEX MARITAL STATUS (circle) S M W D E-Mail Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ . SOCIAL WHOM MAY WE THANK

EMPLOYER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SECURITY #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FOR REFERRING YOU?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TYPE OF INS. INS.

DENTAL INS.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_GROUP #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_TEL. #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SUBSCRIBER NAME SOCIAL DATE OF

(IF OTHER THAN SELF)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SECURITY #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_BIRTH \_\_\_\_\_\_\_\_\_EMPLOYER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for your visit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency information--Name, Address, and Telephone No. of an individual we can call.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name, address, and tel. no. of your physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last complete physical? .Are you taking any medication now? Yes  No 

If Yes, please list all Medications\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Have you ever taken Fosomax, Novartis, Zometa, Aredia, Reclast, or related medications for Osteoporosis? Yes  No **

Are you allergic to: Antibiotics Codeine Aspirin  Local Anesthetics Or any other Medications?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke cigarettes?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes  No  How many per day?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes  No  How many per day?

Do you take Aspirin on a regular basis? Yes  No 

Have you ever been hospitalized? If so give name of hospital, reason and dates. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your blood pressure Normal Low High

Have you ever been tested for Hepatitis? Yes  No  Don’t Know 

Have you had any blood transfusions? Yes  No  Don’t Know 

Are you being treated with immunosuppressive drugs? Yes  No  Don’t Know 

Do you have a history of cold sores, fever blisters. or canker sores? Yes  No  Don’t Know 

Do you consume alcohol on a daily basis? Yes  No 

Have you experienced any recent weight change? Yes  No 

Do you anticipate becoming pregnant in the near future? Yes  No  Don’t Know 

Women: Are you pregnant? Yes  No 

Are you taking birth control pills? Yes  No 

**TURN OVER**

**Do you have or have you ever been informed that you had any of the following(Please Circle):**

Chest pains Glaucoma Thyroid Problems

Heart Disease Hormonal Problems Ulcers

Tuberculosis or Lung Disease Latex Allergies Anemia

Diabetes Psychiatric Problems Aids or HIV+

Allergies or Hives Artificial Joint Sinus Trouble

Heart Murmur Stroke Bruise Easily

Rheumatic Fever Epilepsy or Seizures Enlarged Lymph Nodes

Prolonged Sore Throat Kidney Problems Acid Reflux (G.R.D.)

Cancer or Leukemia Arthritis Asthma

Prosthetic Valves or Joints Prolonged Bleeding Problems Jaundice

Postural Hypotension (fainting spells) Sexually transmitted diseases(Gonorrhea, Syphilis, Genital Herpes)

Please add any disease, condition, or problem not listed.

How often do you brush your teeth? How often do you floss?

Have you ever had a reaction to any Latex product? (like gloves or balloons) Yes  No Don’t Know 

Does food catch between your teeth? Yes  No Don’t Know 

Do you clench or grind your teeth while sleeping or during the day? Yes  No Don’t Know 

Do you feel pain when your teeth come in contact with hot, cold, sweet, or sour? Yes  No Don’t Know 

Do you gag easily? Yes  No Don’t Know 

Do you wear full or partial dentures? Yes  No 

Have you ever used: Nitrous Oxide  Medication prior to treatment 

**PAYMENT IS EXPECTED AT THE TIME OF VISIT**

I understand that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment and that this includes all non-covered procedures of any insurance plan we may participate with. If I have Dental and/or Medical insurance I agree that this office may use computer generated insurance forms with “signature on file” to e-mail, eclaim, or mail my claims. I also agree that if I suspend or terminate my care and treatment, any fees for services rendered me will be immediately due and payable. Accounts requiring additional statements due to excessive lateness are liable for Finance charges to be applied to past due amounts at the rate of 2% per month( $15- minimum fee). Additionally it is agreed that should the fee for the professional services not be paid in accordance with the provisions herein, there shall be included in the computation of a collection fee is added. The amount due, reasonable attorney's fees in the sum of 33% of the total amount due, plus applicable finance charges and disbursements, allowances and costs provided by law. The undersigned also hereby authorizes the Doctor to perform all the necessary diagnostic procedures deemed appropriate to make a thorough diagnosis of the patient's dental or oral-facial needs including x-rays, study models, photographs, medications, and the use of local anesthetic agents.

**I also hereby acknowledge that I have been given the opportunity to review or, if requested, have received** **a copy of this practice’s Notice**

**of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this notice.**

**PLEASE NOTE THAT IN ORDER TO KEEP RECEPTION ROOM TIME TO THE MINIMUM,**

**THERE WILL BE A CHARGE FOR APPOINTMENTS CANCELED W/O 48 HOURS NOTICE**

Patient's Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_

Guardian or Spouse's Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_(sign only if accepting responsibility for payment)

Dentist's Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_

