Patient Health Record

The information on this form is necessary for our records. It is considered strictly confidential. Please complete all parts.

NAME _____ _____
First MI Last Preferred Name

HOME ADDRESS _____ How long? _____
Street City State Zip

E-MAIL _____ PHONE _____
(Home) (Work) (Cell)

SEX: MALE ☐ FEMALE ☐ MARITAL STATUS: SINGLE _____ MARRIED _____ OTHER _____

BIRTH DATE _____ SOCIAL SECURITY NUMBER _____

PLACE OF EMPLOYMENT _____ HOW LONG _____
Name and Address

PHYSICIAN _____ PHONE _____
Name and Address

WHO REFERRED YOU TO THIS OFFICE? _____ PERSON RESPONSIBLE FOR THIS ACCOUNT _____

DO YOU HAVE DENTAL INSURANCE? Yes ☐ No ☐ INSURANCE COMPANY _____

To reach you unexpectedly (to change app., etc.), who could we contact outside the immediate family?

_____
Name Address Phone

MEDICAL HISTORY

Have you ever had or been treated for:

AIDS or ARC	Yes ☐	No ☐
Heart Disease	Yes ☐	No ☐
Rheumatic fever	Yes ☐	No ☐
Abnormal blood pressure	Yes ☐	No ☐
Ulcers	Yes ☐	No ☐
Tuberculosis or lung disease	Yes ☐	No ☐
Diabetes - Type _____	Yes ☐	No ☐
Epilepsy	Yes ☐	No ☐
Anemia	Yes ☐	No ☐
Congenital heart lesions	Yes ☐	No ☐
Heart murmur	Yes ☐	No ☐
Jaundice	Yes ☐	No ☐
Asthma or hay fever	Yes ☐	No ☐
Sinus trouble	Yes ☐	No ☐
Hepatitis - Type _____	Yes ☐	No ☐
Arthritis	Yes ☐	No ☐
Stroke	Yes ☐	No ☐
Mitral Valve Prolapse	Yes ☐	No ☐
Drug abuse, alcohol abuse	Yes ☐	No ☐
Depression	Yes ☐	No ☐
Transplant	Yes ☐	No ☐

Do you take any blood thinning medication?	Yes ☐	No ☐
Are you now under the care of a Physician?	Yes ☐	No ☐
Are you now taking any medication?	Yes ☐	No ☐
Please list _____		
_____		(Use back if needed)
_____		
Are you allergic or sensitive to anything?	Yes ☐	No ☐
Please list _____		
Do you have any type of prosthesis or joint replacement? (artificial joint, heart valve, etc.)	Yes ☐	No ☐
Please list _____		
Have you ever been hospitalized?	Yes ☐	No ☐
For what? _____		
Have you been tested for HIV?	Yes ☐	No ☐
Are you HIV positive?	Yes ☐	No ☐
Do you use tobacco products?	Yes ☐	No ☐
Type _____ How much _____		
Do you need to take pre-medication prior to any dental treatment? _____	Yes ☐	No ☐

FEMALES ONLY
Are you pregnant? _____ Due Date _____
Do you take birth control pills _____

DENTAL HISTORY

Reason for visit _____

Last dental visit _____ Reason _____

PERMIT FOR TREATMENT

This is to certify that I consent to the performing of dental and oral surgical procedures agreed to be necessary or advisable. Including the use of anesthesia as indicated, and I will assume responsibility for fees associated with those procedures. Also, I have read the above questions and answered them to the best of my ability.

Patient's Signature (parent, if a minor) _____ **Date** _____

STAFF NOTES: