

PATIENT HEALTH RECORD

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

1. PERSONAL INFORMATION

Today's Date: _____ Referred By: _____

Name: _____
(Last) (First) (M.I.)

Date of Birth: _____

Sex: Male Female

SSN: _____

Single Married Spouse's name: _____

Address: _____

Employer: _____

City: _____

Occupation: _____

State: _____ Zip: _____

Name of Guardian (if under 18): _____

Home Phone: _____

(Last) (First) (M.I.)

Work Phone: _____

SSN of Guardian (if under 18): _____

Cell Phone: _____

Emergency contact: _____

Email address: _____

2. INSURANCE INFORMATION

Primary Dental Insurance: _____

Group # / Employer: _____

Name of Subscriber (if other than self): _____

Date of Birth: _____ SSN: _____

Secondary Dental Insurance: _____

Group # / Employer: _____

Name of Subscriber (if other than self): _____

Date of Birth: _____ SSN: _____

3. MEDICAL INFORMATION

Are you allergic to: Penicillin? Y N

Codeine? Y N

Latex? Y N

Other Medications? _____

Are you taking any medication? Y N

For what purpose? _____

Are you subject to prolonged bleeding? Y N

Do you use tobacco? Y N

Date of last physical exam: _____

(Women) Are you pregnant? Y N

If yes, how long? _____

Have you ever taken phen phen? Y N

Do you clench or grind your teeth? Y N

When was your last dental exam? _____

4. MEDICAL HISTORY

Y N Heart disease/defect

Y N Rheumatic Fever

Y N Heart Murmur

Y N Heart Surgery

Y N Pacemaker

Y N Diabetes

Y N Cancer/Tumor

Y N High Blood Pressure

Y N Epilepsy

Y N Anemia

Y N Artificial joints or other Prosthesis

Y N Ulcers

Y N Stroke

Y N Tuberculosis or lung disease

Y N Asthma or Hay Fever

Y N Sinus Trouble

Y N Hepatitis, Jaundice, or Liver trouble

Y N Glaucoma

Y N Venereal Disease

Y N Immune deficiency or HIV

Y N Radiation Treatment

Y N Surgery

Any other disease: _____

Physician: _____

Physician's Number: _____

I am financially responsible for my account. 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 State Signature. (If the patient is under 18, the guardian who signs this form assumes full responsibilities.)

Signature: _____

Date: _____

Payment is due in full at the time of treatment unless prior arrangements have been approved.

Medical History Reviewed

Dr. _____

Date: _____