PATIENT HEALTH RECORD

In order to help us provide proper dental services to you, please answer the following questions. There are two sides to be completed. PLEASE PRINT.

Date _____

Patient's Name _____
What do you prefer to be called? _____
_____
Address: Street _____
City _____
State _____ Zip _____
Date of Birth _____
Social Security # _____
Who may we thank for referring you?
_____
Sex: M F Height _____ Weight _____
Family Physician _____

Home Phone Number _____
Work Phone Number _____
Cell Phone Number _____
Email Address _____
Place of Employment _____
City _____
State _____ Zip _____
Marital Status: S M W D Sep
Spouse's Name _____
Name of closest relative and relationship:
_____
Phone Number _____

If Minor:
Name of Mother _____
Work Phone _____
Place of Employment _____

Name of Father _____
Work Phone _____
Place of Employment _____

Do you have Dental Insurance? Yes No
If yes, please complete the following:
Name of Insured _____
Name of Insurance Co. _____
Does your spouse have insurance that covers you? _____

I.D.# _____
Group # _____

DENTAL HEALTH

Reason for visit _____
When was your last dental visit? _____

Have you ever had any serious problem associated with previous dental treatment? ..... Yes No
How often do you brush your teeth?
_____
What texture brush do you use? (Circle One)
SOFT MEDIUM HARD
How often do you floss? _____
Do your gums bleed while brushing or flossing? ..... Yes No
Have you been treated for or told you have periodontal (gum) disease in the past? ..... Yes No
Are your teeth sensitive? ..... Yes No
Do you ever experience bad breath? ..... Yes No
Are you satisfied with your smile? ..... Yes No

Do your gums feel tender or swollen? ..... Yes No
Do you clench/grind your teeth while sleeping or during the day? ..... Yes No
Do your jaws ever feel tired? ..... Yes No
Do you have frequent headaches? ..... Yes No
Do you have any lumps or sores in your mouth? ..... Yes No
Do you feel very nervous about having dental treatment? ..... Yes No
Were you satisfied with your previous dental care? ..... Yes No
Would you like your teeth to be whiter? .. Yes No
Do you snore? ..... Yes No
If yes, does it affect your sleep or others close to you? ..... Yes No

MEDICAL HISTORY

1. Have you been a patient in the hospital during the past two years? ..... Yes No
2. Have you been under the care of a medical doctor during the past two years? ..... Yes No
3. Have you taken any medicine or drugs during the past two years? ..... Yes No
   Please list _____
4. Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications or dental anesthetics or latex? ..... Yes No
   Please list _____
5. Has anyone ever told you that you need to be premedicated before dental treatment? ..... Yes No
6. Circle any of the following which you have had or have at present:

Heart Failure or Trouble	Emphysema	HIV Positive
Angina Pectoris or Chest Pain	Cough	AIDS / AIDS related complex
High Blood Pressure	Tuberculosis (TB)	Hepatitis A (infectious)
Shortness of Breath	Persistent Cough	Hepatitis B (serum)
Heart Murmur	Bloody Cough	Hepatitis Non A-Non B
Mitral Valve Prolapse	Asthma	Liver Disease
Rheumatic Fever	Hay Fever	Yellow Jaundice
Scarlet Fever	Thyroid Disease	Hemophilia or Excessive Bleeding
Artificial Heart Valve	Diabetes	Blood Transfusion
Heart Pacemaker	Radiation Treatment	Drug Addiction
Artificial Joint-Hip, Knee, Etc.	Chemotherapy	Cold Sores
Arthritis/Rheumatoid Arthritis	Anemia	Herpes
Stroke	Cancer or Tumor	Epilepsy or Seizures
Kidney Trouble	Cortisone Medicine	Fainting or Dizzy Spells
Ulcers	Glaucoma	Nervousness
Organ Transplant	Pain in Jaw Joints	Psychiatric Treatment
Venereal Disease,Syphilis,Gonorrhea,etc	Bruise Easily	Sickle Cell Disease

   Other _____

7. Have you ever undergone treatment with a bisphosphonate medication such as Fosamax, Boniva, Zometa, Bonefos or others? ..... Yes No
8. Do your ankles swell during the day? ..... Yes No
9. Do you smoke or chew tobacco? ..... Yes No
10. Have you lost or gained more than 10 pounds in the past year? ..... Yes No
11. Are you on any special diet? ..... Yes No
12. WOMEN: Are you pregnant now? ..... Yes No
    Are you taking birth control medications? ..... Yes No
    Do you anticipate becoming pregnant? ..... Yes No

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform this office at the next appointment. I understand I am financially responsible for all charges not paid by insurance. I also understand that I may be charged a 1.5% finance charge per month (18% annually) if my balance goes beyond 30 days.

_____ _____

Date Signature of Patient, Parent, Guardian

_____ _____

Date Signature of Doctor