PATIENT HEALTH RECORD

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Spouse or Legal Guardian _____
Last Name First Name Initial

Address _____ Home Phone _____

City _____ State _____ Zip _____ Cell Phone _____

Sex ❑ M ❑ F Age _____ Birthdate _____ Height _____ Weight _____

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

In case of emergency notify: _____ Home Phone _____ Work Phone _____ Cell Phone _____

If you are completing this form for a patient:

What is your name? _____

What is your relationship to the patient? _____

MEDICAL HEALTH

General Health (please check) EXCELLENT ❑ GOOD ❑ FAIR ❑ POOR ❑

Name and address of physician _____

Last visit to physician _____ For what purpose _____

Are you taking any medication now: Yes ❑ No ❑ For what purpose _____

List any medication(s) you are now taking: _____

_____

Have you ever had any serious illness or operation: Yes ❑ No ❑

Please describe _____

Have you had, or do you have at present:

Heart disease	Yes ❑	No ❑	Chemical dependency	Yes ❑	No ❑
Rheumatic fever	Yes ❑	No ❑	Angina	Yes ❑	No ❑
Abnormal blood pressure	Yes ❑	No ❑	Heart pacemaker	Yes ❑	No ❑
Ulcers	Yes ❑	No ❑	Asthma or hay fever	Yes ❑	No ❑
Tuberculosis or lung disease	Yes ❑	No ❑	Sinus trouble	Yes ❑	No ❑
Diabetes	Yes ❑	No ❑	Cancer or Cancer treatment	Yes ❑	No ❑
Epilepsy	Yes ❑	No ❑	Hepatitis	Yes ❑	No ❑
Anemia	Yes ❑	No ❑	Arthritis	Yes ❑	No ❑
Congenital heart lesions	Yes ❑	No ❑	Stroke	Yes ❑	No ❑
Joint replacement	Yes ❑	No ❑	Glaucoma	Yes ❑	No ❑
Surgery with pins or plate	Yes ❑	No ❑	Herpes	Yes ❑	No ❑
Heart murmur, Heart valve problems	Yes ❑	No ❑	AIDS	Yes ❑	No ❑
Jaundice	Yes ❑	No ❑	HIV positive	Yes ❑	No ❑

Have you been hospitalized in the last 5 years ..... Yes ❑ No ❑

Have you ever been treated with radiation therapy ..... Yes ❑ No ❑

Are you allergic to: Penicillin ❑ Codeine ❑ Local injected anesthetics ❑ Other medications ❑ _____ None ❑
Material Allergies: Latex ❑ Metal ❑ Other ❑ _____ None ❑

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 pregnant? ❑ Y ❑ N Nursing? ❑ Y ❑ N Taking birth control pills? ❑ Y ❑ N

(over)

Reason for visit: _____

When was your last dental visit? _____

How do you feel about the appearance of your teeth: _____

Have you ever been interested in cosmetically changing your smile? ..... Yes ❑ No ❑

Are you interested in teeth whitening? ..... Yes ❑ No ❑

Have you ever had any serious problem associated with previous dental treatment ..... Yes ❑ No ❑

If so, explain: _____

_____

Do your gums bleed while brushing? ..... Yes ❑ No ❑

Do you avoid brushing any part of your mouth because of pain? ..... Yes ❑ No ❑

If yes, what part? _____

Do you chew on only one side of your mouth? ..... Yes ❑ No ❑

Do your gums feel tender or swollen? ..... Yes ❑ No ❑

Do you clench or grind your jaws while sleeping or during the day? ..... Yes ❑ No ❑

Do you have jaw pain or TMJ problems? ..... Yes ❑ No ❑

Do you wear dentures? ..... Yes ❑ No ❑

If yes, when were they made? _____

Is there anything concerning your past or present medical or dental history which you feel the doctor should know about? ..... Yes ❑ No ❑

If yes, please describe: _____

_____

I certify that I have read, understood and personally reviewed the above questions and answers and that to the best of my knowledge that they are true and correct. If I ever have any change in my health, or medications change, I will inform the Doctor of Dentistry on the next appointment without fail.

The undersigned hereby authorizes this office to release all records to insurance companies and any specialists for continuing treatment.

I understand that the Dentists practicing in this office are independent practitioners and are not controlled or directed by Dental Health Services or any professional corporation.

_____ _____

Date Patient Signature
(Parent's signature if patient is a minor)

HEALTH HISTORY UPDATE:

I have reviewed my previous health history form and as of this date there is no change.

_____	_____	_____	_____
Date	Signature	Date	Signature
_____	_____	_____	_____
Date	Signature	Date	Signature

SUMMARY (For office use only)

_____

Doctor's Signature