PATIENT HEALTH RECORD

Date _____ Date of Birth _____

Name (Last, First, Middle) _____

Address _____ City _____ Zip _____

Home Phone _____ Work Phone _____ Cell _____

E-Mail Address: _____

SS# _____ Sex _____ Weight _____ Height _____

Employer _____ Occupation _____

Driver's Licensed Number and State _____

Spouse Name _____ Parent Name (If Minor) _____

Employer _____ Work No. _____ ext. _____

Do you have dental insurance? ☐ Yes ☐ No

Employee Name _____DOB _____

Employer _____

Insurance Company _____

Social Security No. _____ Policy No. _____ Group No. _____

Are you covered by another dental policy? ☐ Yes ☐ No

Employee Name _____DOB_____

Employer _____

Insurance Company _____

Social Security No. _____ Policy No. _____ Group No. _____

Who may we thank for referring you to our office? _____

DENTAL HEALTH

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental x-rays _____

Address _____

Check (n) if you have had problems with any of the following:

☐ Bad breath	☐ Grinding teeth	☐ Sensitivity to hot
☐ Bleeding gums	☐ Loose teeth or broken fillings	☐ Sensitivity to sweets
☐ Clicking or popping jaw	☐ Periodontal treatment	☐ Sensitivity when biting
☐ Food collection between teeth	☐ Sensitivity to cold	☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

Have you ever had any serious problem associated with previous dental treatment? ☐ Yes ☐ No

If so, describe _____

Do you use an oral irrigator? (Water Pik) ☐ Yes ☐ No

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

If so, what area? _____

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

If so, why? _____

Have any of your previous dentists told you that you have gum disease or a gum problem? ☐ Yes ☐ No

If so, what did they tell you? _____

Do you clench or grind your teeth during the day or night? ☐ Yes ☐ No

Have you ever had pain in your jaw in or around your ear? ☐ Yes ☐ No

Do you have a clicking jaw joint or have you ever experienced any inability to move your jaw or open your mouth widely? ☐ Yes ☐ No

Do you wear dentures? ☐ Yes ☐ No

If so, for how long _____ Why were your teeth lost? _____

Do you usually have many cavities? ☐ Yes ☐ No

Do you frequently lose or break fillings? ☐ Yes ☐ No

Do you gag easily? ☐ Yes ☐ No

Are you familiar with the term "preventive dentistry"? ☐ Yes ☐ No

Are you interested in improving your smile? ☐ Yes ☐ No

If so, how _____

_____

In case of an emergency, who should be notified? _____ Phone No. _____

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

General Health ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of Physician _____ Phone No. _____

Address _____

Last complete physical _____

Are you under a physician's care now? ☐ Yes ☐ No

If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No

If yes, please explain: _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No

If yes, please explain: _____

Are you taking any medications, pills or drugs including herbal supplements? ☐ Yes ☐ No

If yes, please explain: _____

Do you take, or have taken, Phen-Fen or Redux? ☐ Yes ☐ No

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No

Are you on a special diet? ☐ Yes ☐ No Do you use tobacco? ☐ Yes ☐ No

Do you use controlled substances? ☐ Yes ☐ No

Artifical (prosthetic) heart valve? ☐ Yes ☐ No Previous infective endocarditis? ☐ Yes ☐ No

Damaged valves in transplanted heart? ☐ Yes ☐ No

Congential heart disease (CHD)

- Unrepaired, cyanotic CHD? ☐ Yes ☐ No
- Repaired (completely) in last 6 months? ☐ Yes ☐ No
- Repaired CHD with residual defects? ☐ Yes ☐ No
- Are you taking a blood thinner? ☐ Yes ☐ No If so name _____

Women: Are you pregnant/Trying to get pregnant? ☐ Yes ☐ No

- Taking oral contraceptions? ☐ Yes ☐ No
- Nursing? ☐ Yes ☐ No

Have you ever been told you have Dry Mouth? ☐ Yes ☐ No

Do you take medication that cause Dry Mouth? ☐ Yes ☐ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain:_____

Do you have, or have you had, any of the following?

Acid Reflux/Heartburn	☐ Yes ☐ No	Excessive Bleeding	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No
AIDS/HIV Positive	☐ Yes ☐ No	Excessive Thirst	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No
Alzheimer's Demential	☐ Yes ☐ No	Fainting Spells/Dizziness	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Frequent Cough	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No
Angina	☐ Yes ☐ No	Frequent Diarrhea	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No
Arthritis/Gout	☐ Yes ☐ No	Frequent Headaches	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Genital Herpes	☐ Yes ☐ No	Pain in Jaw Joints	☐ Yes ☐ No
Artificial Joint	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Parathyroid Disease	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Hay Fever	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No
Autoimmune Disease	☐ Yes ☐ No	Heart Attack/Failure	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Renal Dialysis	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No	Heart Pacemaker	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Breathing Problem	☐ Yes ☐ No	Heart Trouble/Disease	☐ Yes ☐ No	Rheumatism	☐ Yes ☐ No
Bruise Easily	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Hepatitis A	☐ Yes ☐ No	Sickle Cell Disease	☐ Yes ☐ No
Chemotherapy/Radiation	☐ Yes ☐ No	Hepatitis B or C	☐ Yes ☐ No	Sinus trouble	☐ Yes ☐ No
Chest Pains	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Stomach/Intestinal Disease	☐ Yes ☐ No
Cold Sores/Fever Blisters	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Congenital Heart Disorder	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Swelling of Limbs	☐ Yes ☐ No
Convulsions	☐ Yes ☐ No	Hives or Rash	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Cortisone Medicine	☐ Yes ☐ No	Hyper/Hypoglycemia	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	HPV	☐ Yes ☐ No	Tumors or Growths	☐ Yes ☐ No
Drug Addiction	☐ Yes ☐ No	Irregular Heartbeat	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Epilepsy or Seizures	☐ Yes ☐ No	Leukemia	☐ Yes ☐ No	Weight Loss/Surgery	☐ Yes ☐ No
				Yellow Jaundice	☐ Yes ☐ No

MEDICAL UPDATES

I have read my MEDICAL HISTORY dated_____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	BP	REVIEWED BY
_____	_____	None ☐	_____	_____	Dr._____
_____	_____	None ☐	_____	_____	Dr._____
_____	_____	None ☐	_____	_____	Dr._____
_____	_____	None ☐	_____	_____	Dr._____
_____	_____	None ☐	_____	_____	Dr._____
_____	_____	None ☐	_____	_____	Dr._____
_____	_____	None ☐	_____	_____	Dr._____
_____	_____	None ☐	_____	_____	Dr._____
_____	_____	None ☐	_____	_____	Dr._____

Have you ever had any other serious illness not checked above? Discuss_____ ☐ Yes ☐ No

Do you wish to talk to the Dentist privately about any problem? _____ ☐ Yes ☐ No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the Dentist and staff at the next appointment without fail.

x_____Date_____

PATIENT SIGNATURE (PARENT OR GUARDIAN)

In an effort to keep dental costs down while also keeping a high level of professional care, fees must be paid as follows:

Prepayment or payment at the time of service.
Credit card payment at the time of service.

As a courtesy to our patients, we will complete and submit your dental insurance. Most dental insurance does not cover 100% of the charges incurred. We will try to determine the benefits allowable under your policy. We will estimate your copayment and deductible, which is due at the time of service. When a check is received from your insurance company, your account will be credited. You will receive either a bill for the balance or a refund from our office. Professional care is provided to you — our patient, and not to an insurance company.

Patients participating in HMO/CAPITATION plans, or any other special program, are required to pay for services as they are provided.

Broken appointments can be a serious problem. We reserve the right to charge a fee for failed or broken appointments within 24 hour notice. Some HMO/CAPITATION programs permit broken appointment fees as part of their contract.

There is a $25.00 returned check fee charge for checks returned from your bank.

In the event of default of payment of any amount due, your account may be placed in the hands of an agency or attorney for collection or legal action. You will be charged an additional fee equal to the cost of collection including agency and attorney fees and court costs incurred and permitted by law governing these transactions. This fee will be at least one third of the balance.

Your signature on this form indicates that you understand and agree to the above office policies.

Signature (Responsible Party) _____ Date _____

I authorize release of any dental information, to process an insurance claim. I authorize the payment of group dental benefits, otherwise payable to me to the named provider for services.

Signature (Patient, Parent/Guardian) _____ Date _____