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? ❑ 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 HEALTH

General Health ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Name of physician _____ Phone No. _____

Address _____

Last complete physical _____ Have you been hospitalized? _____

If so, when and for what _____

Are you taking any medication now? ❑ Yes ❑ No Including Herbals

If so, please list them with their dosages _____

_____

_____

Do you have a current medical problem? ❑ Yes ❑ No

If so what _____

Are you allergic to: Penicillin_____ Codeine_____ Anesthetics_____ Latex_____

Aspirin_____ Acrylic_____ Metal_____ Other Medications _____

Are you pregnant? ❑ Yes ❑ No If yes, Due Date?_____

Are you on birth control pills? ❑ Yes ❑ No If yes, please be aware that antibiotic will alter the effectiveness of you birth control pill and other precautions should be used while on antibiotic therapy.

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._____

Do you now have or have you ever had any of the following? Please check appropriate boxes.

* If yes to any of the starred conditions, please call prior to your appointment...premedication may be required.

Heart Murmur*	❑ Yes ❑ No	Recent Weight Loss	❑ Yes ❑ No
Mitral Valve Prolapse*	❑ Yes ❑ No	Frequent Diarrhea	❑ Yes ❑ No
Rheumatic Fever*	❑ Yes ❑ No	Diabetes	❑ Yes ❑ No
Artificial Heart Valve*	❑ Yes ❑ No	Excessive Thirst	❑ Yes ❑ No
Heart Pace Maker*	❑ Yes ❑ No	Hypoglycemia	❑ Yes ❑ No
Hepatitis A (Infectious)*	❑ Yes ❑ No	Liver Disease	❑ Yes ❑ No
Hepatitis B or C*	❑ Yes ❑ No	Tobacco Use	❑ Yes ❑ No
Artificial Joint*	❑ Yes ❑ No	Night Sweats	❑ Yes ❑ No
Heart Trouble/Disease	❑ Yes ❑ No	Yellow Jaundice	❑ Yes ❑ No
Irregular Heart Beat	❑ Yes ❑ No	Kidney Problems	❑ Yes ❑ No
Angina/Chest Pain	❑ Yes ❑ No	Renal Dialysis	❑ Yes ❑ No
Heart Attack/Failure	❑ Yes ❑ No	Thyroid Disease	❑ Yes ❑ No
Congenital Heart Disorder	❑ Yes ❑ No	Parathyroid Disease	❑ Yes ❑ No
Scarlet Fever	❑ Yes ❑ No	Arthritis/Gout	❑ Yes ❑ No
Heart Surgery	❑ Yes ❑ No	Osteporosis	❑ Yes ❑ No
High Blood Pressure	❑ Yes ❑ No	Rheumatism	❑ Yes ❑ No
Low Blood Pressure	❑ Yes ❑ No	Pain in Jaw Joints	❑ Yes ❑ No
Blood Disease	❑ Yes ❑ No	Cortisone Medicine	❑ Yes ❑ No
Unexplained Fever	❑ Yes ❑ No	Venereal Disease	❑ Yes ❑ No
Bruise Easily	❑ Yes ❑ No	AIDS	❑ Yes ❑ No
Anemia	❑ Yes ❑ No	HIV Positive	❑ Yes ❑ No
Excessive Bleeding	❑ Yes ❑ No	Genital Herpes	❑ Yes ❑ No
Sickle Cell Disease	❑ Yes ❑ No	Drug Addiction/Alcohoism	❑ Yes ❑ No
Hemophilia (Bleeding Problem)	❑ Yes ❑ No	Tatoos	❑ Yes ❑ No
Leukemia	❑ Yes ❑ No	Cold Sores	❑ Yes ❑ No
Recent Blood Transfusion	❑ Yes ❑ No	Fever Blisters	❑ Yes ❑ No
Swelling of Limbs	❑ Yes ❑ No	Herpes	❑ Yes ❑ No
Lung Disease	❑ Yes ❑ No	Stroke	❑ Yes ❑ No
Phen-Fen Ever Taken?	❑ Yes ❑ No	Convulsions	❑ Yes ❑ No
Breathing Problem	❑ Yes ❑ No	Epilepsy or Seizures	❑ Yes ❑ No
Shortness of Breath	❑ Yes ❑ No	Fainting or Dizziness	❑ Yes ❑ No
Frequent Cough	❑ Yes ❑ No	Glaucoma	❑ Yes ❑ No
Hay Fever	❑ Yes ❑ No	Tumors or Growths	❑ Yes ❑ No
Sinus Trouble	❑ Yes ❑ No	Nervousness	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Psychiatric Care	❑ Yes ❑ No
Bloody Sputum	❑ Yes ❑ No	Alzheimer's Disease	❑ Yes ❑ No
Emphysema	❑ Yes ❑ No	Allergies (Medicines)	❑ Yes ❑ No
Tuberculosis	❑ Yes ❑ No	Allergies (Pollen Dust)	❑ Yes ❑ No
Cancer	❑ Yes ❑ No	Hives or Rash	❑ Yes ❑ No
X-Ray Treatments (Radiation)	❑ Yes ❑ No	Need Premedication?	❑ Yes ❑ No
Chemotherapy	❑ Yes ❑ No	Cholesterol	❑ Yes ❑ No
Stomach/Intestinal Disease	❑ Yes ❑ No	Gastric Bypass Surgery	❑ Yes ❑ No
Ulcers	❑ Yes ❑ No	Migraine	❑ Yes ❑ No

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 _____