Patient Health Record

#_____

In order to help us render the proper dental services to you, would you please be kind enough to answer the following questions. Please note the space for remarks for any answers that require clarification or any other information you think we should have. Thank you for your cooperation.

Date: _____ **Patient Name:** _____
(LAST) (FIRST) (MIDDLE)

Address: _____, _____, _____, _____ **Phone:** (___)_____-_____
(STREET) (CITY) (STATE) (ZIP)

Sex: M / F **Social Security Number:** _____/_____/_____ **Cell:** (___)_____-_____

Date of Birth: ___/___/___ **Marital Status:** _____ **Driver's License Number:** _____

Responsible Party: _____ **Address:** _____ **Phone:** (___)_____-_____

Employer: _____ **Address:** _____ **Phone:** (___)_____-_____

Spouse's Name: _____ **Social Security Number:** _____/_____/_____

Spouse's Employer: _____ **Address:** _____ **Phone:** (___)_____-_____

Name/Address of Other Nearest Relative: _____ **Phone:** (___)_____-_____

Do You Have Dental Insurance? YES / NO **Insurance Company:** _____ **Group No.** _____

Referred By: _____ **Insurance I.D. No.** _____

DENTAL HISTORY

☐Yes	☐No	Bleeding Gums	☐Yes	☐No	Have You Ever Had Gum Treatments
☐Yes	☐No	Bad Taste, Odor or Breath	☐Yes	☐No	Pain or Noise in Your Jaw Joint
☐Yes	☐No	Tooth Sensitive To Hot, Cold, Sweets,Bite	☐Yes	☐No	Burning Tongue Feeling
☐Yes	☐No	Loose Teeth	☐Yes	☐No	Orthodontic Treatment
☐Yes	☐No	Gum Boil or Abscess	☐Yes	☐No	Bite Corrected By Grinding
☐Yes	☐No	Trench Mouth	☐Yes	☐No	Prolonged Bleeding After Extraction
☐Yes	☐No	Canker Sores or Cold Sores	☐Yes	☐No	Adverse Reaction To Dental Anesthetic
☐Yes	☐No	Breathe Through Your Mouth	☐Yes	☐No	Grind or Clench Your Teeth at Night/Day
☐Yes	☐No	Pack Food Between Your Teeth			

When Were Your Teeth Last Cleaned in a Dental Office? _____

Do You Use:

__ Manual Toothbrush __ Electric Toothbrush: Type _____
__ Dental Floss __ Water Pik
__Proxy Brush __Stim –U-Dents
__Toothpick __Other:_____

How Often Do You Brush?_____**Times a Day** **Floss?**_____**Times a Day**

INFORMED CONSENT

1. I am responsible for ALL charges related to service provided me at the usual and customary charges of the dental office. I acknowledge there will be a charge to process dental insurance forms unless I pay for all services directly to the dental office at the time of treatment.
2. I hereby grant authority to: The Dental Group and/or the dentist(s) in charge of my care, to administer any treatment, to administer such anesthetics or drugs, and to perform such operations as may be deemed necessary in the diagnosis and treatment of my case, I acknowledge that I have been informed of the risks and possible consequences of the operation proposed and do authorize the above doctor(s) to proceed. We will inform you of proposed treatment after examination.

SIGNED_____

Patient or nearest relative in the case when the patient is a minor or physically or mentally incompetent.

MEDICAL HISTORY

PATIENT NAME _____ **CHART NUMBER** _____

General Health (Please Check): ☐Excellent ☐Good ☐Fair ☐Poor **Date of Last Complete Physical:** ___/___/___

Name of Physician: _____ **Address:** _____ **Phone:** (___)_____-_____

Are You Taking Any Medications? ☐YES ☐NO

Have You Taken or Are You Now Taking:

__Nitroglycerine __Insulin
__Aspirin __Digitalis
__Tranquilizers __Cortisone
__Coumadin __Phen Phen
__ Drugs for Blood Pressure
__Anticoagulants (blood-thinners)

Please List All Medications You Are Taking:	For What Reason:

ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD A REACTION TO:

☐Yes ☐No Penicillin
☐Yes ☐No Latex
☐Yes ☐No Local Injected Anesthetic
☐Yes ☐No Codeine
☐Yes ☐No Sulfa Drugs
☐Yes ☐No Aspirin
☐Yes ☐No Erythromycin
☐Yes ☐No Valium
☐Yes ☐No Other:_____
_____

☐Yes ☐No **Do You Require Antibiotics for Routine Dental Treatment?**
Name of Antibiotic: _____ **Dose:** _____
*Women Advisory: Antibiotics may render birth control medications ineffective.

☐Yes ☐No Have you ever taken **Fosamax**, **Actonel**, or any other formulation of the class of medications known as **Bisphosphonates** used for managing osteoporosis and also used in chemotherapy for treatment of certain cancers.

Do You Have Or Have You Ever Been Treated For Any Of The Following:

☐Yes ☐No Major Operation:_____
☐Yes ☐No Heart Disease:_____
☐Yes ☐No Heart By-Pass Surgery:_____
☐Yes ☐No Heart Attack: When:_____
☐Yes ☐No Chest Pains
☐Yes ☐No Stroke: When:_____
☐Yes ☐No Congenital Heart Lesions
☐Yes ☐No Heart Murmur /Mitral Valve Prolapse
☐Yes ☐No Rheumatic Fever
☐Yes ☐No Abnormal Blood Pressure ☐ High ☐ Low
☐Yes ☐No Diabetes: ☐ Self ☐ Family Member
☐Yes ☐No Hepatitis or Jaundice Type:_____
☐Yes ☐No Tuberculosis or Lung Disease
☐Yes ☐No Thyroid Problems: Type:_____
☐Yes ☐No Kidney or Liver Disease/Infection
☐Yes ☐No Cancer:Type_____
☐Yes ☐No ☐ Radiation or ☐ Chemotherapy
☐Yes ☐No Cardiac Pacemaker
☐Yes ☐No Sinus Trouble
☐Yes ☐No Serious Illness_____
☐Yes ☐No A.I.D.S. or Exposed to AIDS
☐Yes ☐No HIV Positive/High Risk Activity
☐Yes ☐No Venereal Disease
☐Yes ☐No Herpes Infection
☐Yes ☐No Immune Deficiency Disease: Type:_____
☐Yes ☐No Lymes Disease or Multiple Sclerosis
☐Yes ☐No Lupus or Chronic Fatigue Syndrome
☐Yes ☐No Epilepsy or Convulsions
☐Yes ☐No Any Infectious/Contagious Disease
☐Yes ☐No Anemia or other blood disorder
☐Yes ☐No Stomach Ulcers or Problems
☐Yes ☐No Arthritis
☐Yes ☐No Hypoglycemia/Hyperglycemia
☐Yes ☐No Asthma or Trouble Breathing
☐Yes ☐No Joint Replacement or Implant:Type_____
☐Yes ☐No Glaucoma
☐Yes ☐No Other_____
_____

DO YOU HAVE ANY OF THE FOLLOWING:

☐Yes ☐No Swollen Ankles, Feet or Hands
☐Yes ☐No Bleeding Tendency or Bruise Easily
☐Yes ☐No Hormone Problems
☐Yes ☐No Severe or Frequent Headaches
☐Yes ☐No Do You Have Excessive Urination/Thirst?
☐Yes ☐No Dizziness or Fainting Spells
☐Yes ☐No Drug Rehabilitation or Alcoholism
☐Yes ☐No Psychiatric Care or Therapy
☐Yes ☐No Often Under Stress or Tension
☐Yes ☐No Nervousness
☐Yes ☐No Have You Reached Menopause?
☐Yes ☐No Do You Smoke? How Many ____per Day?
☐Yes ☐No Do You Drink Alcoholic Beverages?
☐Yes ☐No Are You Pregnant? How Many Months?_____
☐Yes ☐No Other_____
_____

OFFICE USE: **MEDICAL HISTORY REVIEW**

DOCTOR	*DATE*	*DOCTOR*	*DATE*	*DOCTOR*	*DATE*