

PATIENT HEALTH RECORD

Date _____

Name _____ Spouse's Name _____

Address _____ City _____ State _____ Zip _____

Home phone _____ Business phone _____ Cell phone _____

Employer _____ E-mail address _____

Date of Birth _____ Sex _____ Height _____ Weight _____

Occupation _____ Social Security No. _____ - _____ - _____ Single _____ Married _____

Closest Relative _____ Phone _____

Whom may we thank for referring you? _____

MEDICAL HEALTH

Name and address of physician _____

Have you been under a physician's care during the past 2 years? _____ For _____

Have you been treated in a hospital in the past 2 years? _____ For _____

Have you ever had major surgery? If yes, what? _____

If female: Are you taking hormones or birth control? _____ Are you pregnant or nursing? _____

Have you ever had a blood test for hepatitis? _____ Were you vaccinated? _____

Have you had canker or cold sores on your lips, tongue, gums or body? _____

Are you now taking or have you taken any prescription drugs during the past year? _____

If yes, what medications _____

Are you allergic to: Penicillin Codeine Local anesthetics Other _____

Have you had or do you now have:

	yes	no		yes	no
Abnormal blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis.....	<input type="checkbox"/>	<input type="checkbox"/>
AIDS.....	<input type="checkbox"/>	<input type="checkbox"/>	Herpes.....	<input type="checkbox"/>	<input type="checkbox"/>
Allergies.....	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice.....	<input type="checkbox"/>	<input type="checkbox"/>
Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Angina.....	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	Organ transplant.....	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valves.....	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>
Artificial joints.....	<input type="checkbox"/>	<input type="checkbox"/>	Polio.....	<input type="checkbox"/>	<input type="checkbox"/>
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged bleeding.....	<input type="checkbox"/>	<input type="checkbox"/>
Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged cough.....	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy.....	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric treatment.....	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart problems.....	<input type="checkbox"/>	<input type="checkbox"/>	Radiation therapy.....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever.....	<input type="checkbox"/>	<input type="checkbox"/>
Drug dependency.....	<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell anemia.....	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy.....	<input type="checkbox"/>	<input type="checkbox"/>	Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>
Fainting.....	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	Veneral disease.....	<input type="checkbox"/>	<input type="checkbox"/>

Have you any disease, condition, or problem not previously listed? _____

DENTAL HEALTH QUESTIONNAIRE

	yes	no
Are your teeth sensitive to hot, cold, or sweets?	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to chewing?	<input type="checkbox"/>	<input type="checkbox"/>
Have you noticed any swelling around your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed when brushing or flossing?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any loose teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Does food catch between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>
Do you snore?	<input type="checkbox"/>	<input type="checkbox"/>
Are you interested in improving your smile?	<input type="checkbox"/>	<input type="checkbox"/>
Are you interested in whiter teeth?	<input type="checkbox"/>	<input type="checkbox"/>

How often do you floss your teeth? _____

When was your last dental visit? _____ For what reason? _____

DENTAL INSURANCE INFORMATION

Name of Insurance Company _____	Group # _____
Name of Insured _____	SSN of Insured _____
Employer of Insured _____	Insured's birthdate _____
Relation to Patient _____	Telephone # _____

FINANCIAL ARRANGEMENTS

Payment is due in full at the time of treatment. For your convenience we accept payment by cash, check, Mastercard or Visa.

INSURANCE: We are happy to file the necessary forms to see that you receive the full benefits of your coverage. However, **we can make no guarantee of any estimated coverage** because the insurance policy is an agreement between you and the insurance company. Our office will do everything possible to assist you in receiving the fullest benefits of your policy; however **we require all patients to be directly responsible for all charges.**

MISSED APPOINTMENTS

We will make every effort to arrange appointments that fit into your schedule. We do ask that you kindly give us at least **24 hours** notice should an emergency prevent you from keeping your appointment, as this will allow us to accommodate other patients in need of treatment. Should you habitually miss appointments, we may elect to dismiss you from our practice.

RESPONSIBLE PARTY SIGNATURE _____ DATE _____