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

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

If yes, what medications? _____

Pharmacy and phone number _____

Are you allergic to: ☐ Penicillin ☐ Codeine ☐ Local anesthetics ☐ Other _____

Have you ever had or do you now have:

	yes	no
Abnormal blood pressure	☐	☐
AIDS	☐	☐
Allergies	☐	☐
Anemia	☐	☐
Angina	☐	☐
Arthritis	☐	☐
Artificial heart valves	☐	☐
Artificial joints	☐	☐
Asthma	☐	☐
Cancer	☐	☐
Chemotherapy	☐	☐
Congenital heart problems	☐	☐
Diabetes	☐	☐
Drug dependency	☐	☐
Epilepsy	☐	☐
Fainting	☐	☐
Glaucoma	☐	☐
Heart disease	☐	☐
Heart murmur	☐	☐

	yes	no
Hepatitis	☐	☐
Herpes	☐	☐
Jaundice	☐	☐
Kidney disease	☐	☐
Liver disease	☐	☐
Organ transplant	☐	☐
Pacemaker	☐	☐
Polio	☐	☐
Prolonged bleeding	☐	☐
Prolonged cough	☐	☐
Psychiatric treatment	☐	☐
Radiation therapy	☐	☐
Rheumatic fever	☐	☐
Sickle cell anemia	☐	☐
Stroke	☐	☐
Thyroid disease	☐	☐
Tuberculosis	☐	☐
Ulcers	☐	☐
Venereal disease	☐	☐

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

DENTAL HEALTH OUESTIONNAIRE

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

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 Birthday _____

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, and credit card.

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. We are NOT a participating provider with ANY insurance plans.**

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

_____ _____