Date_____

PATIENT HEALTH RECORD

Name_____ Soc. Sec. #_____
Last Name First Name Initial

Spouse or Legal Guardian_____ Marital Status _____
Last Name First Name Initial

Address _____ Home Phone_____

City_____ State_____ Zip_____ Cell Phone_____

Sex □M □F Age _____ Birthdate _____ Height _____Weight_____

Patient employed by_____ Occupation _____

Business Address_____ Business Phone_____

Whom may we thank for referring you?_____

In case of emergency notify:_____ Home Phone_____ Work Phone_____ Cell Phone_____

If you are completing this form for a patient:

What is your name? _____

What is your relationship to the patient? _____

MEDICAL HEALTH

General Health (please check) EXCELLENT □ GOOD □ FAIR □ POOR □

Name and address of physician _____

Last visit to physician_____ Reason_____

Are you taking any medication now? Yes □ No □ Reason_____

List any medication(s) you are now taking: _____

_____

Have you ever had any serious illness or operation: Yes □ No □

Please describe _____

Have you ever had, or do you have at present:

Heart Disease	Yes□	No□	Chemical Dependency	Yes□	No□
Rheumatic fever	Yes□	No□	Angina	Yes□	No□
Abnormal blood pressure	Yes□	No□	Heart pacemaker	Yes□	No□
Ulcers	Yes□	No□	Asthma or hay fever	Yes□	No□
Tuberculosis or lung disease	Yes□	No□	Sinus trouble	Yes□	No□
Diabetes	Yes□	No□	Cancer or Cancer treatment	Yes□	No□
Epilepsy	Yes□	No□	Hepatitis	Yes□	No□
Anemia	Yes□	No□	Arthritis	Yes□	No□
Congenital heart lesions	Yes□	No□	Stroke	Yes□	No□
Joint replacement	Yes□	No□	Glaucoma	Yes□	No□
Surgery with pins or plates	Yes□	No□	Herpes	Yes□	No□
Heart Murmur, Heart valve problems.	Yes□	No□	AIDS	Yes□	No□
Jaundice	Yes□	No□	HIV positive	Yes□	No□

Have you been hospitalized in the last 5 years Yes□ No□

Have you ever been treated with radiation therapy Yes□ No□

Are you allergic to: Penicillin□ Codeine□ local injected anesthetics□ Other medications□_____ None□

Material Allergies: Latex□ Metal□ Other□ _____ None□

Are you subject to prolonged bleeding? Yes□ No□

Are you subject to fainting spells? Yes□ No□

Do you have excessive urination and/or thirst Yes□ No□

Women: Are your pregnant? Yes□ No□ Nursing? Yes□ No□ Taking birth control pills Yes□ No□

Reason for today's visit_____

When was your last dental visit?_____

How do you feel about the appearance of your teeth:_____

Have you ever been interested in cosmetically changing your smile?.....Yes□ No□

Are you interested in teeth whitening?.....Yes□ No□

Have you ever had any serious problems associated with previous dental treatment?.....Yes□ No□

If so, explain_____

_____

Check (√) any of the following that apply:

□ Bad breath
□ Sensitivity to hot
□ Bleeding gums
□ Sensitivity to sweets
□ Clicking or popping jaw
□ Sensitivity when biting
□ Jaw pain or TMJ problems
□ Clenching or grinding jaws during day or sleeping
□ Grinding teeth
□ Periodontal treatment
□ Loose or broken fillings
□ Sores or growths in mouth
□ Sensitivity to cold
□ Food collecting between teeth
□ Tender or swollen gums
□ Wear dentures

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

Is there anything concerning your past or present medical or dental history which you feel the doctor should know about?.....Yes□ No□

If yes, please describe: _____

_____

What is your email address (if any) _____

How may we contact you (check all that apply):

phone□ cell phone□ email□ text□

I certify that I have read, understood and personally reviewed the above questions and answers and that to the best of my knowledge that they are true and correct. If I ever have any change in my health or medications change, I will inform the Doctor of Dentistry on the next appointment without fail.

The undersigned hereby authorizes this office to release all records to insurance companies and any specialists for continuing treatment.

I understand that the Dentists practicing in this office are independent practioners and are not controlled or directed by Dental Health Services or any professional corporation.

_____ _____
Date Patient Signature
(Parent's signature if patient is a minor)

HEALTH HISTORY UPDATE: (ONLY FOR FUTURE VISITS)

I have reviewed my previous health history form and as of this date there is no change.

_____ Date	_____ Signature	_____ Date	_____ Signature
_____ Date	_____ Signature	_____ Date	_____ Signature
_____ Date	_____ Signature	_____ Date	_____ Signature

Summary (For office use only)

_____
Doctor's Signature