PATIENT INFORMATION AND HEALTH RECORD

Name_____ Date of Birth_____ Male Female
(Last) (First) (Middle)

Address_____ Cell Phone_____
(Street)

_____ Home Phone_____
(City) (State) (Zip)

_____
(Occupation) (Employer) (Address) (Phone)

Spouse's Name_____

_____
(Occupation) (Employer) (Address) (Phone)

(If child, please list parent's names and each of their occupations, employer address and phone.)

Father_____

Mother_____

Person Responsible for account_____
(Name) (Phone)

_____
(Address) (Relationship to patient)

Do you have dental insurance? Yes No

If yes, please fill out insurance information sheet. *(See attached)*

Who may we thank for referring you to our office?_____

Name of relative & phone number in case of emergency:_____
(other than spouse and relative to patient)

MEDICAL HISTORY

Name of physician:_____

Date of last complete physical:_____

Hospitalized or had surgery within last 2 years? Yes No If so, what?_____

Have you ever had joint replacement? Yes No If so, when?_____

Do you have abnormal blood pressure? High Low No

Are you taking any medications or supplements? Yes No

If so, what are you taking?_____

_____

Do you have any allergies? Penicillin Codeine Local Anesthetics Latex Other:_____

Do you smoke? If so, how much?_____

Women: Are you pregnant/trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Have you ever had or have any of the following conditions? *(Check all that apply)*

Heart Disease	Yes	No	Mitral Valve Prolapse	Yes	No
Rheumatic Fever	Yes	No	Heart Murmur	Yes	No
Tuberculosis or Lung Disease	Yes	No	Jaundice	Yes	No
Diabetes	Yes	No	Kidney Disease	Yes	No
Epilepsy	Yes	No	Liver Disease	Yes	No
Convulsions	Yes	No	Pacemaker	Yes	No
Anemia	Yes	No	Organ Transplant	Yes	No
Angina	Yes	No	Psychiatric Treatment	Yes	No
Congenital Heart Lesions	Yes	No	Sickle Cell Anemia	Yes	No
Arthritis	Yes	No	Thyroid Disease	Yes	No
AIDS/HIV	Yes	No	Sexually Transmitted Disease	Yes	No

(OVER)

Drug Dependence	Yes	No	Asthma	Yes	No
Prolonged Bleeding	Yes	No	Sinus Troubles	Yes	No
Herpes	Yes	No	Hepatitis	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No
Chemotherapy	Yes	No	Stroke	Yes	No
Radiation	Yes	No	Fainting Spells	Yes	No

If you checked yes to any of the diseases or conditions in the list, please explain:_____

_____

DENTAL HISTORY

Reason for present dental visit:_____

Any problems requiring immediate attention?_____

Date of last dental visit:_____

Any serious problems with prior dental treatment? Yes No If so, what?_____

Do your gums bleed when you brush? Yes No Do your gums feel swollen or tender? Yes No

Have you had a periodontal treatment? Yes No If so, when?_____

Do you feel twinges of pain with hot foods or liquids? Yes No Cold foods or liquids? Yes No Sweets? Yes No

Do you clench or grind your teeth? Yes No Do your jaws ever feel tired or ache? Yes No

Have you ever had orthodontic treatment? Yes No If so, when?_____ Do you have any loose teeth? Yes No

Do you have any cracked or broken teeth? Yes No Do you have any missing teeth? Yes No

Have they been replaced? Yes No If so, by what treatment?_____

Are you happy with this treatment? Yes No How do you feel about the appearance of your smile?_____

Have you ever had a cosmetic dental procedure to improve your smile? Yes No Are you happy with the result? Yes No

Have you ever had nitrous oxide or "gas" for previous dental treatment? Yes No

Have you had an unpleasant dental experience? Yes No

Please add anything else that you feel is important or would make your visit more positive:_____

_____

Signature, Patient's or if Child, Parent's Signature Date Dr.'s Signature

Signatures give us consent for treatment

**** Office Use Only ****

HEALTH HISTORY UPDATES

Date:_____ No Changes Yes:_____

Date:_____ No Changes Yes:_____

Date:_____ No Changes Yes:_____

Date:_____ No Changes Yes:_____

Date:_____ No Changes Yes:_____

Date:_____ No Changes Yes:_____

Date:_____ No Changes Yes:_____

Date:_____ No Changes Yes:_____

Date:_____ No Changes Yes:_____

Date:_____ No Changes Yes:_____

Date:_____ No Changes Yes:_____

Date:_____ No Changes Yes:_____