Emergency Contact Phone/Relationship

_____

Laura Fauchier, DDS
915 Barrington Pkwy, Suite C
Marion, IA 52302
(319) 377-4867

In order to help us render the proper dental services to you, would you please be kind enough to answer the following confidential 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.

Patient Health Record

Date_____

PERSONAL

Patient's Name_____ Date of Birth_____
Last First Middle Mo. Day Yr.

Preferred Name or Nickname_____ SSN _____

Mailing Address: _____

Residence Phone:_____ Cell Phone: _____

Marital Status: Single Married Widowed Divorced Gender:

Firm employed by:_____ Occupation _____

Business Address_____ Business Phone: _____

May we call you at your business phone? Yes ☐ No ☐

Spouse's Name _____

Spouse's employer:_____ Occupation: _____

Day of week and time of day preferred for appointments:_____

Whom may we thank for referring you? _____

Reason for this visit: _____

If the patient is an adult who does not make their own health decisions, please indicate reason and name of person designated to do so

_____

FINANCIAL

Party responsible for payment of account and/or Insured Subscriber: _____
Name

Mailing Address_____
Street City State Zip

Relationship_____

Dental Insurance Co._____ Policy #_____ **Subscriber's SS#**_____

Insurance Co. Address:_____ **Subscriber's Date of Birth**_____
Mo. Day Yr.

MEDICAL HEALTH & HISTORY

Name and address of your physician _____

Have you been hospitalized in the last 2 years? _____

For what reason? _____

Date of last complete physical_____ Were there any significant findings? Yes ☐ No ☐

Are you under the care of a physician for a medical condition? Yes ☐ No ☐ For what reason? _____

Medication	Purpose

(Please turn over)

Do you smoke or chew? ..... Yes ☐ No ☐

Have you ever been diagnosed as having:

Heart disease/attack/surgery ..... Yes ☐ No ☐

Rheumatic fever ..... Yes ☐ No ☐

Implants, joins, heart valves ..... Yes ☐ No ☐

Cancer (type_____).....Yes☐ No ☐

Sexually transmitted disease (type_____).....Yes☐ No ☐

Heart murmur ..... Yes ☐ No ☐

Abnormal blood pressure.....Yes ☐ No ☐

Tuberculosis or lung disease ..... Yes ☐ No ☐

Diabetes ..... Yes ☐ No ☐

Epilepsy..... Yes ☐ No ☐

Congenital heart lesions..... Yes ☐ No ☐

Cold sores or fever blisters ..... Yes ☐ No ☐

Have you ever received radiation therapy? ..... Yes ☐ No ☐

Are you occupationally exposed to X-rays/Radiation? ..... Yes☐ No ☐

Asthma / obstructive lung disease.....Yes ☐ No ☐

Hepatitis .....Yes ☐ No ☐

Arthritis .....Yes ☐ No ☐

Stroke .....Yes ☐ No ☐

Glaucoma ..... Yes ☐ No ☐

AIDS.....Yes ☐ No ☐

Do you snore?..... Yes☐ No☐

Do you have sleep apnea?..... Yes☐ No☐

Are you allergic to: Penicillin ☐ Codeine ☐ Local injection anesthetics ☐ Sulfa ☐ Latex ☐ Other medications ☐

Are you subject to prolonged bleeding? . . . . . .Yes ☐ No ☐

Are you subject to fainting spells? . . . . . .Yes ☐ No ☐

Are you pregnant? Yes ☐ No ☐ How long?_____

DENTAL HEALTH & HISTORY

Name of former Dentist_____Address_____

Approximate date of last dental appointment:_____

Were X-rays taken? Yes ☐ No ☐ Approximately how many? _____

Approximately date when teeth were last cleaned: _____

How often do you have your teeth cleaned?_____

If so, Explain:_____

Have you ever had: Braces? Yes ☐ No ☐ Root canal treatment? Yes ☐ No ☐

Wisdom teeth removed? Yes ☐ No ☐ Periodontal treatment? Yes ☐ No ☐

Are you very apprehensive about having dental treatment? . . . . . Yes ☐ No ☐

Are you satisfied with the health and appearance of your mouth?. . . . . Yes ☐ No ☐

What things about your past dental experiences have you disliked the most?_____

Do you have any teeth bothering you now? If so, please explain: _____

Please add anything else you feel is important: _____

Is there anything about your smile or teeth that you would like to change? _____

Would you like to bleach your teeth?_____

X_____

Thank you for yourcooperation.
Our goal is your optimal health.

Patient Signature

(or Parent if patient is a minor)

Signature is also for "Signature on File" purposes for insurance claims