

Emergency Contact #



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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: M F

Firm employed by: _____ Occupation _____

Business Address _____ Business Phone: _____

May we call you at your business phone? Yes No

Spouse's Name _____

Spouses employed by: _____ 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: _____
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

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

Implants, joins, heart valves Yes No

Cancer (type _____) Yes No

Sexually transmitted disease (type _____) Yes No

Heart murmur Yes No

Asthma or obstructive lung disease. Yes No

Hepatitis Yes No

Arthritis. Yes No

Stroke Yes No

Glaucoma Yes No

AIDS. 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? _____

Have you ever been pre-medicated for dental appointments by your MD or dentist? Yes No What medication? _____

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? _____

Have you ever had any serious problem associated with previous treatment? Yes No

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? _____

**Thank you for your cooperation.
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