CONFIDENTIAL PATIENT HEALTH RECORD

#_____

NAME: _____ D.O.B._____ Home Phone_____
(Last) (First) (Middle)

Work Phone _____ Cellphone _____

Address: _____ SSN:_____/_____/_____
(Street) (City) (State) (Zip)

Check appropriate box: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Your E-Mail Address_____ Referred By: _____

RESPONSIBLE PARTY: _____ Relationship to Patient:_____

D.O.B.: _____ Driver License # _____ SSN:_____/_____/_____

Address _____ Home Phone: _____

Name / Address of Nearest Relative: _____ Phone:_____
(In Case of Emergency)

MEDICAL HEALTH

General health (please check): EXCELLENT ❑ GOOD ❑ FAIR ❑ POOR ❑ Last complete physical _____

Name of physician _____ Phone: _____

Are you under medical treatment now? Yes ❑ No ❑ Are you taking any medication now? Yes ❑ No ❑

Which medications? _____

Do you require antibiotics before routine dental treatment? Yes ❑ No ❑ Do you use tobacco/alcohol/cocaine or other drugs? Yes ❑ No ❑

Have you ever been hospitalized for any surgical operation or serious illness? Yes ❑ No ❑

Are you **ALLERGIC** to: Penicillin ❑ Codeine ❑ Local injected anesthetics ❑ Latex ❑ Iodine ❑ Aspirin ❑ Sulfadrugs ❑ Other _____

Women: Are you pregnant? Yes ❑ No ❑ Are you nursing? Yes ❑ No ❑ Are you taking birth control pills? Yes ❑ No ❑

Advisory: Antibiotics may render birth control medications ineffective.

Do you have or have you had any of the following?

Yes	No		Yes	No		Yes	No	
❑	❑	Heart disease	❑	❑	Tuberculosis or lung disease	❑	❑	Sinus trouble
❑	❑	Rheumatic fever	❑	❑	Diabetes	❑	❑	Arthritis
❑	❑	High/Low Blood Pressure	❑	❑	Radiation therapy	❑	❑	Stroke
❑	❑	Angina / Chest Pain	❑	❑	Fainting/Seizures	❑	❑	Glaucoma
❑	❑	Emphysemia	❑	❑	Sexually transmitted diseases	❑	❑	Joint Replacement / Implant
❑	❑	Heart Murmur	❑	❑	AIDS or HIV Infection	❑	❑	Leukemia
❑	❑	Cardiac Pacemaker	❑	❑	Hepatitis/Jaundice	❑	❑	Cancer
❑	❑	Anemia	❑	❑	Liver Disease	❑	❑	Prolonged Bleeding
❑	❑	Congenital Heart Lesions	❑	❑	Kidney Disease	❑	❑	Thyroid problems
❑	❑	Ulcers/Stomach troubles	❑	❑	Asthma/Respiratory problems	❑	❑	Infectious/contagious disease
❑	❑	Heart attack	❑	❑	Hay fever/Allergies	❑	❑	Frequently tired/Easily winded
❑	❑	Recent weight loss	❑	❑	Swollen ankles	❑	❑	Other _____

INFORMED CONSENT

1. I am responsible for ALL charges related to services provided to me at the usual and customary charges of the dental office.
2. I hereby grant authority to the dentist(s) in charge of my care to administer any treatment, anesthetics or drugs and to perform such operations as may be deemed necessary in the diagnosis and treatment of my case. I acknowledge that I have been informed of the risks, benefits, alternatives and possible consequences of the treatment proposed and I authorize the treatment.
3. Dental treatment may include examination, X-rays, cleaning, gum disease treatment, fillings, root canals and prosthodontics usually with local anesthesia. If the cavity in the tooth is very deep, the removal of the nerve or the tooth may be necessary. We would like to provide you with complete information regarding the risks and benefits of your dental treatment.

Signed X _____ Date _____
Signature of Patient or Parent if minor

(Continue other side)

DENTAL HEALTH

Reason for visit: _____ When was your last dental visit? _____

Prior dentist name: _____ What was last treatment? _____

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

If so, explain: _____

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

What texture brush do you use? ❑ SOFT ❑ MEDIUM ❑ HARD ❑ NYLON ❑ NATURAL

Do you feel twinges of pain when your teeth come in contact with: ❑ Hot ❑ Cold ❑ Sweets ❑ Sours

Do your gums bleed while brushing or flossing? Yes ❑ No ❑

Do your gums feel tender or swollen? Yes ❑ No ❑

Do you chew on only one side of your mouth? Yes ❑ No ❑

Do you bite your lips or cheeks frequently? Yes ❑ No ❑

Have you has any difficult extractions in the past? Yes ❑ No ❑

Do you have frequently headaches? Yes ❑ No ❑

Do you clench or grind your jaws while sleeping or during the day? Yes ❑ No ❑

Have you ever had prolonged bleeding following extractions? Yes ❑ No ❑

Have you ever had instruction on the correct method of brushing your teeth and care of your gums? Yes ❑ No ❑

Have you ever experienced any of the following problems in your jaw?:

Clicking ❑ *Pain(joint,ear,side of face)* ❑ *Difficulty in openning or closing?* ❑ *Difficulty in chewing?* ❑

Would you like to change anything about your smile? Yes ❑ No ❑

Explain:_____

Please add anything you feel is important: _____

INSURANCE INFORMATION

Name of Insured _____ Relationship to patient_____

Employer _____ Address_____ Work Phone _____

Insurance Company _____ GROUP# _____

Additional Insurance Yes ❑ No ❑

Name of Insured _____ Relationship to patient_____

Employer _____ Address_____Work Phone _____

Insurance Company _____ GROUP# _____

If patient is a student, Name of School/College _____

I, the undersigned, hereby authorize the release of any information including the diagnosis and the records of any treatments or examinations rendered, to my insurance company or companies.
This release is solely for the purpose of facilitating the billing and reimbursement, directly to the Dental Provider, of insurance benefits under which I am entitled.

X

_____ DATE

_____ SIGNED

ANNUAL MEDICAL HISTORY UPDATES

I have reviewed the attached MEDICAL HISTORY. My (or the patient's) health information has changed as follows (if no change, write "NO CHANGE"): _____

_____

X _____ _____ _____

Signature of Patient (or Guardian) Date Update reviewed by Dr.

I have reviewed the attached MEDICAL HISTORY. My (or the patient's) health information has changed as follows (if no change, write "NO CHANGE"): _____

_____

X _____ _____ _____

Signature of Patient (or Guardian) Date Update reviewed by Dr.

I have reviewed the attached MEDICAL HISTORY. My (or the patient's) health information has changed as follows (if no change, write "NO CHANGE"): _____

_____

X _____ _____ _____

Signature of Patient (or Guardian) Date Update reviewed by Dr.