Patient Health Record

In order to help me render the proper dental services to you, would you please be kind enough to answer the following questions? Please note the space for remarks for any answers that require clarification or any other information you think I should have. Thanks for your cooperation.

Please complete both sides of this form

PERSONAL INFORMATION DATE: _____

(Title) _____
last *first* *middle initial*

Home Address _____ *(city)* _____ *(ZIP)* _____

Home Phone (___) _____ Work Phone (___) _____ Date of Birth ___/___/_____

Employer's Name _____ Address _____

Sex _____ Height _____ Weight _____ SSN _____ Occupation _____

Marital Status _____ Spouse/Guardian's Name _____

Do you have Dental Insurance? _____ If so, what type? _____

Whom may we thank for referring you? _____

MEDICAL HEALTH

How would you characterize your general health? (circle one) (Click Here to Select)

Name and Address of Physician: _____

Last Complete Physical ___/___ (month / year) Are you taking any medication at the present time?_____

If yes, for what purpose? _____

Please circle Y (yes) or N (no) as applicable.

Have you ever had or been treated for…

Heart Disease	Y / N	Rheumatic Fever	Y / N
Ulcers	Y / N	Tuberculosis / Lung Disease	Y / N
Epilepsy	Y / N	Anemia	Y / N
Heart Murmur	Y / N	Jaundice	Y / N
Sinus Trouble	Y / N	Hepatitis	Y / N
Stroke	Y / N	Glaucoma	Y / N
Abnormal Blood Pressure	Y / N	Diabetes	Y / N
Congenital Heart Lesions	Y / N	Asthma / Hay Fever	Y / N
Arthritis	Y / N	HIV / AIDS	Y / N
Nervous Disorders	Y / N	Eating Disorders	Y / N

(please complete both sides)

Reset Form

Are you allergic to: Penicillin? ◯ Y / N ◯ Local Anesthetics? ◯ Y / N ◯
Codeine? ◯ Y / N ◯ Metals? ◯ Y / N ◯
Others? _____

Are you subject to prolonged bleeding?
Are you subject to fainting spells?
Do you have excessive urination and/or thirst?
(Women) Are you pregnant? If so, how long? _____

DENTAL HEALTH

Reason for Visit_____

When was your last dental visit?_____

Have you ever had any serious problem associated with dental treatment? _____

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

Do your gums bleed while brushing?
Do you avoid brushing any part of your mouth due to pain?
Do you clench or grind your teeth while sleeping?
Do you feel twinges of pain when your teeth come in contact with (circle) ☐ Hot / ☐ Cold / ☐ Sweets?
Do your gums feel tender or swollen?
Do you wear dentures?
Do you often have cavities?
Do you lose fillings?
Do you gag easily?
Are you happy with the appearance of your teeth?

Please add anything you feel is important.

OFFICE POLICY: All accounts are payable in full within 30 days of treatment. After 30 days, a service charge will be assessed at the rate of 1.00% per month, a minimum of $5.00. The minimum monthly payment to avoid such a service charge is the larger of 20% of the total amount due or $25.

CONSENT AND AGREEMENT: I hereby authorize the Doctor to take radiographs, study models, photographs, or other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of my dental needs. I also authorize the Doctor to prescribe any and all forms of medication and perform any therapy that may be indicated and agreed upon. I understand that responsibility for payment for dental services provided by this office for me or my dependents is mine.

Signature of patient or responsible party _____ Date _____

(please complete both sides)

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