Patient Health Record

DATE________________________ CELL PHONE __________________ E-MAIL ______________________________

PATIENT NAME ____ HOME PHONE # ______________________

ADDRESS _________________________________ CITY ___________________ STATE ______ ZIP __________

DATE OF BIRTH _____________________ SEX ________ WEIGHT________ HEIGHT_______

MARITAL STATUS Single ☐ Married ☐ Widowed ☐ Divorced ☐

SOCIAL SECURITY # ____

EMPLOYER BUSINESS NAME __________________ WORK PHONE # ____________________ EXT __________

DENTAL INSURANCE NAME _______________________ GROUP # _________ PHONE # ____________________

RESPONSIBLE PARTY (if not same as above)

NAME ____ HOME PHONE ______________ CELL # _______________

ADDRESS _____________________________ CITY ____________________ STATE ______ ZIP __________

DATE OF BIRTH _______________________________ SOCIAL SECURITY # ___________________________

EMPLOYER BUSINESS NAME _______________________ WORK PHONE # ______________ EXT. __________

DENTAL INSURANCE NAME _______________________ GROUP # _________ PHONE # ____________________

METHOD OF PAYMENT ☐ Cash ☐ Check ☐ Insurance ☐ Medicaid ☐ Visa ☐ MC ☐ Discover ☐ Care Credit

MEDICAL HEALTH

General health (please check): EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐

Name and Phone # of physician ____

Last complete physical? _________Are you taking any medication now? Yes ☐ No ☐
Indicate which of the following you have or have had in the past. By checking the box, you will be indicating a **YES** response. By leaving the box blank, you will be indicating a **No** response.

Have you ever been treated for:

☐ Allergies (General)
☐ Allergy to Benadryl (Antihistamine)
☐ Allergy to Lidocaine or Septocaine
☐ Allergy to Codeine (Tylenol 3)
☐ Allergy to Hydrocodone (Lortab, Vicodin)
☐ Allergy to Ibuprofen (Motrin, Advil)
☐ Allergy to Acetaminophen (Tylenol)
☐ Allergy to Latex
☐ Allergy to Penicillin or Amoxicillin
☐ Allergy to Clindamycin
☐ Allergy to Keflex
☐ Allergy to Tetracycline or Minocycline
☐ Anemia
☐ Arthritis
☐ Asprin (Do you take daily?)
☐ Asthma
☐ Bipolar Disorder

☐ Blood Disease
☐ Blood Pressure (High or Low)
☐ Blood Thinners
☐ Cancer
☐ Cough (chronic)
☐ Crohn's Disease
☐ Depression
☐ Diabetes
☐ Epilepsy
☐ Excessive Bleeding
☐ Excessive Thirst, Urination
☐ Fainting
☐ Glaucoma
☐ Heart Disease
☐ Heart Murmur or Mitral Valve Prolapse
☐ Hepatitis A, B, or C
☐ HIV/AIDS

☐ Joint Replacement
☐ Kidney Disease
☐ Liver Disease, Jaundice
☐ Lung and Respiratory Disease
☐ Lupus
☐ Mental Disorder
☐ Multiple Sclerosis
☐ Nerve Disorder
☐ Pacemaker (Do you have one?)
☐ Pregnant Now? Weeks ____
☐ Radiation or Chemotherapy (Circle)
☐ Rheumatic Fever
☐ Sinus Fever
☐ Sleep Apnea Stroke
☐ Thyroid Disease
☐ Tuberculosis
☐ Venereal Disease

If you are Diabetic, are you Type 1 ☐ or Type 2 ☐ ? What medication are you taking for your condition?

____

If you are taking Blood Thinners, what is the name of the medication? ______________________________

____

If you have a history of Heart Disease, please explain.____

____

If you have had Joint Replacement Surgery in the past, please explain. ______________________________

____

Have you been told by your Medical Doctor that you need to pre-medicate with an antibiotic prior to receiving any Dental procedure?

____

Are you taking birth control pills? ☐ Yes ☐ No

Do you have frequent headaches? ☐ Yes ☐ No

Do you think you have TMJ problems? Explain ____

Are you taking or have you ever taken Bisphosphonate medication for osteoporosis or bone cancer? ☐ Yes ☐ No
If yes, circle which one (Fosamax, Boniva, Actonel, Atelvia, Reclast, Other)

Do you smoke ☐ cigarettes, ☐ cigars, ☐ chew tobacco ☐ snuff? How long?___________________________

Do you take herbal or homeopathic supplements? ☐ Yes ☐ No

Please list all medications you are taking for any medical or dental condition as of today's date.
(You may list on a separate piece of paper if needed)

____

____

Person to call in case of emergency:

Name: ____

Phone number______________________ Relationship to patient:_____________________________

Signature (Parent if minor) ____