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. Thank you for your cooperation.

Medical History

1. Are you having pain or discomfort at this time? ..... Yes ❑ No ❑
1. Do you feel very nervous about having dental treatment? ..... Yes ❑ No ❑
1. Have you ever had a bad experience in any dental office? ..... Yes ❑ No ❑
1. Have you been a patient in the hospital during the past 2 years? ..... Yes ❑ No ❑
1. Have you been under the care of a medical doctor during the past 2 years? ..... Yes ❑ No ❑
1. have you taken any medicine or drugs during the past year? ..... Yes ❑ No ❑
1. Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin aspirin, codeine or any drugs or medications **including** local anesthetics? ..... Yes ❑ No ❑
1. Have you ever had any excessive bleeding requiring special treatment? ..... Yes ❑ No ❑
1. Have you had a physical exam within the past year? ..... Yes ❑ No ❑
1. List all the medications you are taking at the present time: _____

_____

Circle any of the following which you **have had** or have at the present time:

Heart failure	Heart disease or attack	Angina Pectoris	Rheumatic Fever	Scarlet Fever
High blood pressure	Heart murmur	Congenital heart lesions	Artificial heart valve	Anemia
Low blood pressure	Heart pacemaker	Heart surgery	Artificial joint	Stroke
Pain in region of ears	Kidney trouble	Ulcers	Chronic sinus	Emphysema
Tuberculosis (TB)	Asthma	Hay fever	Allergies or hives	Diabetes
Rheumatism	Arthritis	Thyroid disease	X-ray or cobalt treatment	Chemotherapy (cancer, leukemia)
Cortisone medicine	Glaucoma	Pain in jaw joints	Bleeding gums	
Hepatitis A (infectious)	Hepatitis B (serum)	Liver disease	Yellow jaundice	AIDS
Hemophilia	Venereal Disease	Cold sores	Genital Herpes	Food collect between teeth
Bruise easily	H.I.V.	Fainting or dizzy spells	nervousness	Blood transfusion
Sickle cell disease	Latex Sensitivity	Osteoporosis treatment	Crohn's disease	Epilepsy or seizures

Do you smoke or use tobacco? ..... Yes ❑ No ❑
When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath or because you are very tired? ..... Yes ❑ No ❑
Do your ankles swell during the day? ..... Yes ❑ No ❑
Do you use more than 2 pillows to sleep with? ..... Yes ❑ No ❑
Have you lost or gained more than 10 pounds in the past year? ..... Yes ❑ No ❑
Do you ever wake up from sleep short of breath? ..... Yes ❑ No ❑
Are you on a special diet? ..... Yes ❑ No ❑
Has your medical doctor ever said you have a cancer or tumor? ..... Yes ❑ No ❑
Do you have any disease, condition, or problem not listed? ..... Yes ❑ No ❑

Women: Are you pregnant now? ..... Yes ❑ No ❑
Do you anticipate becoming pregnant? ..... Yes ❑ No ❑

List all the medications you are taking at the present time: _____

_____

_____

Date:: _____ Patient Signature _____

OVER PLEASE

Personal Information

Today's Date _____

Name _____

Person financially responsible _____ Relationship to you _____

Home address _____

City _____ Zip _____ Home phone _____ Office phone _____

Date of birth _____ Age _____ Social Security # _____

Marital status _____ Spouse's name _____ Referred by _____

Your occupation _____ Employer _____

Employer's address _____ City _____ Years with firm _____

Spouse's occupation _____ Employer _____

Employer's address _____ City _____ Years with firm _____

Addit. billing address _____ City _____ Zip _____

Your physician _____ Phone _____

Former dentist _____ Address _____

Your children's names and ages _____

_____

Date of last dental visit _____

Person to contact in case of emergency _____ Phone _____

spouse ❑ relative ❑ friend ❑

Primary dental insurance coverage

Name of Insured _____ Birthdate _____

Ins. Co. _____ Group # _____

Ins. Co. Address _____

_____

Soc. Sec. # _____

Place of employment _____

Secondary dental insurance coverage

Name of Insured _____ Birthdate _____

Ins. Co. _____ Group # _____

Ins. Co. Address _____

_____

Soc. Sec. # _____

Place of employment _____

Signature _____