Patient Health Record

In order to help us render the proper dental services to you, would you please be kind enough to answer all the following questions. Thank you for your cooperation.

Please start here➔

↑YOUR NAME (Last), (First) (Middle) HOME PHONE ↑

↑TODAY'S DATE REFERRED BY YOUR EMAIL ADDRESS(s) ↑

PERSONAL ADDRESS CITY STATE ZIP CODE CELL PHONE ↑

EMPLOYED BY BUSINESS ADDRESS BUSINESS PHONE ↑

OCCUPATION DATE OF BIRTH SEX HEIGHT WEIGHT DRIVERS LIC. NO. ↑

MARTIAL STATUS (check) SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐

SPOUSE'S NAME OR PARENT EMPLOYED BY BUISNESS PHONE ↑

NEAREST RELATIVE OR FRIEND ADDRESS PHONE ↑

TYPE OF DENTAL INSURANCE (if applicable) GROUP ID SOCIAL SECURITY NO. ↑

INSURANCE ADDRESS INSURANCE PHONE ↑

Please describe or rank order the best way(s) we should contact you for appointment reminders, dental treatment information and other communication from this office. (__ email, __ cell phone, __ home phone, __ business phone, __ text message, _____ other) ↑

MEDICAL HEALTH → GENERAL MEDICAL HEALTH (please check) EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐

↑NAME AND ADDRESS OF YOUR PHYSICIAN PHONE ↑

LAST COMPLETE PHYSICAL (Date)? Are you taking any medication now? .....Yes☐ No☐ For what purpose? ↑

Please list any medications you are taking (prescribed, over the counter, holistic, herbs, home remedies) ↑

Have you ever been treated for:

Heart disease.....Yes☐ No☐
Rheumatic fever.....Yes☐ No☐
Abnormal blood pressure.....Yes☐ No☐
Ulcers.....Yes☐ No☐
Tuberculosis or lung disease.....Yes☐ No☐
Diabetes.....Yes☐ No☐
Epilepsy.....Yes☐ No☐
Anemia.....Yes☐ No☐
Congenital Heart lesions.....Yes☐ No☐
Kidney problems.....Yes☐ No☐
Stroke.....Yes☐ No☐
Glaucoma.....Yes☐ No☐

Hepatitis or liver problems.....Yes☐ No☐
Or been in close contact with anyone with hepatitis .....Yes☐ No☐
Heart murmur.....Yes☐ No☐
Jaundice.....Yes☐ No☐
Asthma or hay fever.....Yes☐ No☐
Sinus trouble.....Yes☐ No☐
Cough.....Yes☐ No☐
Malignancies.....Yes☐ No☐
Arthritis.....Yes☐ No☐
AIDS.....Yes☐ No☐

To your knowledge have you ever been exposed to the HIV/AIDS
Virus?.....Yes☐ No☐
Other_____

ARE YOU ALLERGIC TO? Penicillin ☐ Codeine ☐ Local injected anesthetics ☐ Other ☐ _____

Have you ever been treated with x-ray (other than diagnostic)?.....Yes☐ No☐
Are you subject to prolonged bleeding?.....Yes☐ No☐
Are you subject to fainting spells?.....Yes☐ No☐
Do you have excessive urination and / or thirst?.....Yes☐ No☐
Women: Are you pregnant?.....Yes☐ No☐ How long? _____

DENTAL HEALTH

Reason for visit: _____

When was your last dental visit? _____

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

If so, explain: _____

How can we keep you happy? _____

How often do you brush your teeth? _____

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

How often do you floss? _____

Do your gums bleed while brushing? Yes☐ No☐

Do your gums bleed when flossing? Yes☐ No☐

Do you avoid brushing any part of your mouth because of pain? Yes☐ No☐

If yes, what part? _____

Are your teeth sensitive to hot _____, cold _____, sweet _____, sour_____?

Do you feel pain to any of your teeth when brushing or flossing them? Yes☐ No☐

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

If yes, explain: _____

Do you hear popping, clicking or snapping noises when you chew? Yes☐ No☐

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

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

Do you have headaches or muscle soreness in your face or head? Yes☐ No☐

Do you wear dentures? Yes☐ No☐

Are you aware of any swelling(s) or lump(s) in your mouth? Yes☐ No☐

Where? _____

Do you usually have many cavities? Yes☐ No☐

Do you lose filling or break fillings? Yes☐ No☐

Do you gag easily? Yes☐ No☐

Are you familiar with the term “preventive dentistry”? Yes☐ No☐

How do you feel about your teeth? _____

Are you happy with your smile? _____

Please add anything you feel is important:

_____

_____

APPOINTMENTS: A minimum charge will be made for failed or cancelled appointments without prior notification of 24 hours. This fee covers only a portion of the overhead such as salaries, electric, heat, etc., which still have to be paid whether you are present or not. Once an appointment is made, please remember this time has been reserved for you.

INSURANCE: To avoid misunderstanding regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees. We do not render our services on the basis that insurance companies will pay all our fees. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies. However full (or partial) payment of the bill is necessary before submitting forms for payment. If only partial payment is made, insurance benefits must be assigned to the attending dentist.

FINANCIAL ARRANGEMENTS: Fees for treatment rendered are due in full at the completion of the appointment unless prior arrangements have been made. This office limits all accounts to 30 days without a late payment charge of 1.5% (18%APR). This charge will be placed on all past due accounts, only as allowed by law. Visa, MasterCard, American Express or Discover may be used.

It is a pleasure to serve your dental needs and discuss all treatment with you. We are pleased you have chosen to place the care of your dental health with us. Be assured that the most thorough, conscientious service will be dedicated to this trust. All facilities and personnel of this office are expressly here to serve you and your health.

102810 B

SIGNATURE_____Date_____