

# PATIENT INFORMATION AND HEALTH RECORD

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  Male  Female  
(Last) (First) (Middle)

Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
(Street)

\_\_\_\_\_ Cell Phone \_\_\_\_\_  
(City) (State) (Zip)

\_\_\_\_\_ (Occupation) (Employer) (Address) (Phone)

Social Security # \_\_\_\_\_ Email \_\_\_\_\_

How would you prefer to have your appointments confirmed?  Phone  Email  Text

Spouse's Name \_\_\_\_\_

\_\_\_\_\_ (Occupation) (Employer) (Address) (Phone)

*(If child, please list parent's names and each of their occupations, employer address and phone.)*

Father \_\_\_\_\_

Mother \_\_\_\_\_

Person Responsible for account \_\_\_\_\_  
(Name) (Phone)

\_\_\_\_\_ (Address) (Relationship to patient)

Do you have dental insurance?  Yes  No  
If yes, please fill out insurance information sheet. *(See attached)*

Who may we thank for referring you to our office \_\_\_\_\_

Name of relative & phone number in case of emergency: \_\_\_\_\_  
*(other than spouse and relative to patient)*

## MEDICAL HISTORY

Name of physician: \_\_\_\_\_

Date of last complete physical: \_\_\_\_\_

Hospitalized or had surgery within last 2 years?  Yes  No If so, what? \_\_\_\_\_

Have you ever had joint replacement?  Yes  No If so, when? \_\_\_\_\_

Do you have abnormal blood pressure?  High  Low  No

Are you taking any medications or supplements?  Yes  No

If so, what are you taking? \_\_\_\_\_

Do you have any allergies?  Penicillin  Codeine  Local Anesthetics  Latex  Other: \_\_\_\_\_

Do you smoke? If so, how much? \_\_\_\_\_

Women: Are you pregnant/trying to get pregnant?  Yes  No Taking oral contraceptives?  Yes  No Nursing?  Yes  No

Have you ever had or have any of the following conditions? *(Check all that apply)*

Heart Disease..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic Fever ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Tuberculosis or Lung Disease ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Convulsions ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Organ Transplant ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Angina ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Treatment ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Anemia ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
AIDS/HIV ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Sexually Transmitted Disease..... <input type="checkbox"/> Yes <input type="checkbox"/> No

(OVER)

Drug Dependence .....  Yes  No  
 Prolonged Bleeding .....  Yes  No  
 Herpes .....  Yes  No  
 Cancer .....  Yes  No  
 Chemotherapy .....  Yes  No  
 Radiation .....  Yes  No  
 Sleep Apnea/Snore .....  Yes  No

Asthma .....  Yes  No  
 Sinus Troubles .....  Yes  No  
 Hepatitis .....  Yes  No  
 Glaucoma .....  Yes  No  
 Stroke .....  Yes  No  
 Fainting Spells .....  Yes  No

If you checked yes to any of the diseases or conditions in the list, please explain: \_\_\_\_\_

**DENTAL HISTORY**

Reason for present dental visit: \_\_\_\_\_

Any problems requiring immediate attention? \_\_\_\_\_

Date of last dental visit: \_\_\_\_\_

Any serious problems with prior dental treatment?  Yes  No If so, what? \_\_\_\_\_

Do your gums bleed when you brush?  Yes  No Do your gums feel swollen or tender?  Yes  No

Have you had a periodontal treatment?  Yes  No If so, when? \_\_\_\_\_

Do you feel twinges of pain with hot foods or liquids?  Yes  No Cold foods or liquids?  Yes  No Sweets?  Yes  No

Do you clench or grind your teeth?  Yes  No Do your jaws ever feel tired or ache?  Yes  No

Have you ever had orthodontic treatment?  Yes  No If so, when? \_\_\_\_\_ Do you have any loose teeth?  Yes  No

Do you have any cracked or broken teeth?  Yes  No Do you have any missing teeth?  Yes  No

Have they been replaced  Yes  No If so, by what treatment? \_\_\_\_\_

Are you happy with this treatment?  Yes  No How do you feel about the appearance of your smile? \_\_\_\_\_

Have you ever had a cosmetic dental procedure to improve your smile?  Yes  No Are you happy with the result?  Yes  No

Have you ever had nitrous oxide or "gas" for previous dental treatment?  Yes  No

Have you had an unpleasant dental experience?  Yes  No

Please add anything else that you feel is important or would make your visit more positive: \_\_\_\_\_

Signature, Patient's or if Child, Parent's Signature  
*Signatures give us consent for treatment*

Date

Dr.'s Signature

**\*\*Office Use Only\*\***

**HEALTH HISTORY UPDATES**

Date: \_\_\_\_\_  No Changes  Yes: \_\_\_\_\_

Date: \_\_\_\_\_  No Changes  Yes: \_\_\_\_\_

Date: \_\_\_\_\_  No Changes  Yes: \_\_\_\_\_

Date: \_\_\_\_\_  No Changes  Yes: \_\_\_\_\_

Date: \_\_\_\_\_  No Changes  Yes: \_\_\_\_\_

Date: \_\_\_\_\_  No Changes  Yes: \_\_\_\_\_

Date: \_\_\_\_\_  No Changes  Yes: \_\_\_\_\_

Date: \_\_\_\_\_  No Changes  Yes: \_\_\_\_\_

Date: \_\_\_\_\_  No Changes  Yes: \_\_\_\_\_

Date: \_\_\_\_\_  No Changes  Yes: \_\_\_\_\_

Date: \_\_\_\_\_  No Changes  Yes: \_\_\_\_\_

Date: \_\_\_\_\_  No Changes  Yes: \_\_\_\_\_