Telephone: 731-7660

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# Patient Health Record

DATE_____

NAME (LAST) (FIRST) (MIDDLE)

ADDRESS EMAIL ADDRESS

HOME PHONE WORK PHONE CELL PHONE

DATE OF BIRTH SEX HEIGHT WEIGHT MARITAL STATUS

SOCIAL SECURITY NO. SPOUSE'S NAME

REFERRED BY PARENTS NAME (IF CHILD)

TYPE OF DENTAL INSURANCE (IF APPLICABLE) NAME AND ADDRESS OF PHYSICIAN

## MEDICAL - DENTAL HISTORY

***CHECK YES OR NO***

### PATIENT MEDICAL HISTORY

☐YES ☐NO Are you under any medical treatment now?
☐YES ☐NO Have you had any major operations? If so, what?_____
☐YES ☐NO Have you ever had a serious accident involving head or jaw injuries?
☐YES ☐NO Have you had any adverse response to any drugs including penicillin and aspirin?
☐YES ☐NO Have you ever had any of the following?

☐Heart Ailment
☐High Blood Pressure
☐Low Blood Pressure
☐Respiratory Disease
☐Diabetes
☐Rheumatic Fever
☐Rheumatism or Arthritis
☐Tumors or Growths
☐Any Blood Disease
☐Any Liver Disease
☐Any Kidney Disease
☐Any Stomach or Intestinal Disease
☐Any Venereal Disease
☐Yellow Jaundice or Hepatitis
☐Epilepsy
☐AIDS
☐HIV +

☐YES ☐NO Are you on a diet at this time?
☐YES ☐NO Are you now taking drugs or medications?
☐YES ☐NO Are you allergic to any known materials resulting in - hives, asthma, eczema, etc.?
☐YES ☐NO Do you have any reason to suspect you are not in good health?
☐YES ☐NO Have any wounds healed slowly or presented other complications?
☐YES ☐NO Are you pregnant?
☐YES ☐NO Do you have a history of fainting?
☐YES ☐NO Have you ever had any X-RAY TREATMENTS (other than diagnostic?)
☐YES ☐NO Have you received any donor organs, artifical heart valves, vessels, joint implants or use of a pacemaker?

| CURRENT MEDICATION | REASON |
|---|---|
| | |

### PATIENT MEDICAL HISTORY

☐YES ☐NO Do you have any specific problems?
☐YES ☐NO Do you have pain in or near your ears?
☐YES ☐NO Do you have any unhealed injuries or inflamed areas in or around your mouth?
☐YES ☐NO Have you experienced any growth or sore spots in your mouth?
☐YES ☐NO Does any part of your mouth hurt when clenched?
☐YES ☐NO Have you ever had novocaine anesthetic?
☐YES ☐NO Any reactions or allergic symptoms to novocaine?
☐YES ☐NO Any difficult extractions in the past?
☐YES ☐NO Have you had prolonged bleeding following extractions in the past?
☐YES ☐NO Do your gums bleed?
☐YES ☐NO Have you ever been instructed on the care of your gums?
☐YES ☐NO Do you chew on only one side of your mouth?
☐YES ☐NO Do you habitually clench your teeth during the night or day?
☐YES ☐NO When was the last full mouth X-RAY TAKEN? _____
Where?_____
☐YES ☐NO Any part of your mouth sore to pressures or irritants (cold, sweets, etc.)? If so, locate _____

CERTIFICATION: I certify that the answers given are correct to the best of my knowledge

Signature _____ Date_____

I understand that I am financially responsible for all services not covered by my Insurance Company.

RECERTIFICATION: I certify that there have been no changes in my health except as noted below

| Date | Change | Signature |
|---|---|---|
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