

PATIENT HEALTH RECORD

Date _____

Name _____
Last First Middle

Name you would like us to use in the office _____

Address _____
Street City State Zip Code

Home Phone _____ Business _____ Cell _____

Date of Birth ____/____/____ email address _____

Single _____ Married _____ Separated _____ Widowed _____ Divorced _____

Patient Employed by _____ Present Position _____

Name of Spouse _____ Spouse Employed by _____

Patient's Social Security _____ Spouse's Social Security _____

How did you hear about us or whom do we have to thank you for referring you to us? _____

Purpose of today's visit? _____

Name of Dental Insurance Company? _____

Primary _____ Secondary _____

MEDICAL HEALTH

Name of Physician _____

Have you been under a physicians care during the past two years? _____

If female: Are you taking hormone or birth control? _____ Are you pregnant or nursing? _____

Are you taking an medications? _____ If so, what _____ For? _____

Are you allergic to penicillin _____ Codeine _____ Local Anesthetics _____ Other _____

Have you had or do you now have:

AIDS or HIV positive.....	_____	_____	Fainting.....	_____	_____
Abnormal blood pressure.....	_____	_____	Glaucoma.....	_____	_____
Anemia.....	_____	_____	Heart disease.....	_____	_____
Angina.....	_____	_____	Heart Murmur.....	_____	_____
Artificial Heart Valves.....	_____	_____	Hepatitis.....	_____	_____
Artificial Joints.....	_____	_____	Herpes.....	_____	_____
Asthma.....	_____	_____	Organ Transplant.....	_____	_____
Cancer.....	_____	_____	Pacemaker.....	_____	_____
Chemo Therapy.....	_____	_____	prolonged bleeding.....	_____	_____
Congenital Heart liaisons.....	_____	_____	Psychiatric treatment.....	_____	_____
Diabetes.....	_____	_____	Rheumatic fever.....	_____	_____
Drug Dependency.....	_____	_____	Stroke.....	_____	_____
Epilepsy.....	_____	_____	Mytral Valve Prolapse.....	_____	_____

Any other physical or medical conditions we should be aware of? _____

