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PATIENT HEALTH RECORD

DATE: ___________________ **Email:** ___________________

Mr./ Mrs./ Ms. : ___________________ (Last) (First) (Initial) Date of Birth: ___________________

Address: ___________________ (Street) (City) (State) (Zip Code)

Home #: ___________________ Cell: ___________________

Sex: M / F **Martial Status:** Married / Single / Child

Social Security #: ___________________ Occupation: ___________________

Emergency Contact: ___________________ Phone#: ___________________

Whom may we thank for referring you to us? ___________________

Medical History

What is your general state of health? Excellent ________ Good ________ Fair ________ Poor ________

Name, address and phone number of physican: ___________________

____

Have you been under a physican's care during the last two years? ___________________

Have you been treated in a hospital in the past three years? ___________________

Have you had any minor or major surgery? Please explain ___________________

History with local, general and IV anesthia? ___________________

If Female: Are you pregnant or nursing? ___________________

Do you or have you had any of the following:

	None	Present	Past		None	Present	Past		None	Present	Past
Epilepsy or Seizures	☐	☐	☐	Kidney Problems	☐	☐	☐	Cancer	☐	☐	☐
Fainting or Dizziness	☐	☐	☐	Bruise/Bleeds easily	☐	☐	☐	Chemotherapy	☐	☐	☐
Stroke	☐	☐	☐	Heart Problem	☐	☐	☐	Radiation Therapy	☐	☐	☐
Persistant Cough	☐	☐	☐	Chest Pain/Angina	☐	☐	☐	Thyroid Disease	☐	☐	☐
Emphysema/Bronchitis	☐	☐	☐	High Blood Pressure	☐	☐	☐	AIDS/HIV+	☐	☐	☐
Tuberculosis/PPD+	☐	☐	☐	Rheumatic Fever	☐	☐	☐	Arthritis	☐	☐	☐
Asthma	☐	☐	☐	Heart Murmur	☐	☐	☐	Artifical Joints	☐	☐	☐
Sinus Problems	☐	☐	☐	Mitral Valve Proplapse	☐	☐	☐	Diabetes	☐	☐	☐
Anemia/Sickle Cell	☐	☐	☐	Congenital Heart Lesions	☐	☐	☐	Organ Transplants	☐	☐	☐
Hepatitis A / B / C	☐	☐	☐	Heart Surgery	☐	☐	☐	Osteoporosis /Penia	☐	☐	☐
Liver Disease	☐	☐	☐	Artifical Heart Valves	☐	☐	☐	Snoring	☐	☐	☐
Pneumonia	☐	☐	☐	Pacemaker	☐	☐	☐	Sleep Apnea	☐	☐	☐
Nervousness/Anxious	☐	☐	☐	Fibromyalgia	☐	☐	☐	Dry Mouth	☐	☐	☐
Irregular Heart Beat	☐	☐	☐	Latex Allergy	☐	☐	☐	Tobacco Use	☐	☐	☐

Do you have any conditions, disease, or problems not previously listed? ___________________

Please list any medications you are taking, including over the counter drugs and herbs. Please include dosage and times a day ____

What type of dental treatment do you seek? Immediate care (***Emergency Treatment or pain or broken teeth***) _________
Maintaince Care(***Required treatment only***)________ Comprehensive/ Esthetic (***Required and Elective***) ___________

Please answer the questions below to the best of your knowledge:

When was your last dental visit? ______________ How often did you see your dentist? _______________________

Are you having any dental problems that require immediate attention? ____________________________________

Do you have frequent headaches? ______________ Ear Aches? _______________ How Often? _________________

Is the anything that will cause your muscles to be tired or sore or cause headaches? ________________________

Are your jaws joints painful or tender? ___________ If yes, please describe _________________________________

Have you had trauma to your jaw? ___________ Do your jaw joints pop or click or grate? _____________________

Do your jaws ever feel tired or ache? _____________ Have you ever been told that you have TMJ? ____________

Do you clench or grind your teeth? ______________ At night? _______________ During the Day? ______________

Does your bite feel comfortable? _____________ Have you notice any change in your bite? ___________________

Have you ever been told you have periodontal disease? ____ Have you ever had periodontal treatment? ______

Do your gums bleed while cleaning? ___________ Do your gums ever feel tender or swollen? _________________

How often do you brush you teeth? __________ Floss? __________ Water Jet? __________ Mouth Rinse? ________

Do any of the following cause tooth discomfort? Hot? _______ Cold? _______ Sweets? _______ Chewing? _______

Have you noticed any changes in your teeth? If so please describe ____

Do you have loose teeth? _______ Worn teeth? ________ Broken or chipped teeth? ________ Food traps?______

Can you chew on both sides of your mouth? _________________ Comfortably? ______________________________

Do you lose fillings or break fillings? __________________ Do you usually have cavities? _____________________

Have you ever had orthodontic treatment? _________ When? ________ How long was your treatment? ________

Do you have any missing teeth? ________________ Have they been replaced? ______________________________

Do you have a Fixed bridge? ______ Removable partial? _______ Full dentures?__________ Implants? _________

Are you comfortable with the replacement? ___________ If not, please describe ____________________________

____

How do you feel about the appearance of your smile? ____

What improvement would you like to make in your mouth? ____

____

Please add anything you feel is important ____

____

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination. In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

______________________________________ ____________________
Signature Patient or Guardian Date