PATIENT HEALTH RECORD

Date_____

Name_____ Spouse's Name_____
(last) (first) (initial)

Address_____
(Street) (City) (Zip)

Cell Phone_____ Home Phone_____ Business Phone_____

Date of Birth_____ Sex_____ Height_____ Weight_____

Social Security No._____ Employer_____

Driver's License #_____ E-mail Address_____

Closest Relative_____ Relation _____ Phone_____

Whom may we thank for referring you to our office? _____

"I understand that honest answers to the questions stated below are important to the provision of my dental care, and that I will answer them to the best of my ability.

"I understand that if I am uncertain about the question or how the question relates to my health status I must discuss the problem with the doctor or a member of the office staff.

"I understand that all questions must be answered.

"I understand that the information I provide will not be released without my express permission."

MEDICAL HEALTH

Name and address of physician_____

Have you been under a physician's care during the past 2 years?_____ For_____

Have you been treated in a hospital in the past 2 years?_____ For_____

Have you ever had major surgery?_____

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

Have you ever had a blood test for hepatitis?_____ Were you vaccinated?_____

Have you had cankers or cold sores on your lips, tongue, gums or body? _____

Are you now taking or have you taken any prescription drugs during the past year? _____

For_____

Are you allergic to: [] Penicillin? [] Codeine? [] Local anesthetics? Other?_____

Do you have to pre-medicate before treatments? _____

Have you had or do you now have:

	YES	NO		YES	NO		YES	NO
AIDS	[ ]	[ ]	Drug dependency	[ ]	[ ]	Polio	[ ]	[ ]
Allergies	[ ]	[ ]	Epilepsy	[ ]	[ ]	Prolonged bleeding	[ ]	[ ]
Anemia	[ ]	[ ]	Fainting	[ ]	[ ]	Prolonged cough	[ ]	[ ]
Angina	[ ]	[ ]	Glaucoma	[ ]	[ ]	Psychiatric treatment	[ ]	[ ]
Arthritis	[ ]	[ ]	Heart disease	[ ]	[ ]	Radiation therapy	[ ]	[ ]
Artificial heart valves	[ ]	[ ]	Heart murmur	[ ]	[ ]	Rheumatic fever	[ ]	[ ]
Artificial joints	[ ]	[ ]	Hepatitis	[ ]	[ ]	Sickle cell anemia	[ ]	[ ]
Asthma	[ ]	[ ]	Herpes	[ ]	[ ]	Stroke	[ ]	[ ]
Blood pressure high/low	[ ]	[ ]	Jaundice	[ ]	[ ]	Thyroid disease	[ ]	[ ]
Cancer	[ ]	[ ]	Kidney disease	[ ]	[ ]	Tuberculosis	[ ]	[ ]
Chemotherapy	[ ]	[ ]	Liver disease	[ ]	[ ]	Ulcers	[ ]	[ ]
Congenital heart lesions	[ ]	[ ]	Organ transplant	[ ]	[ ]	Venereal disease	[ ]	[ ]
Diabetes	[ ]	[ ]	Pacemaker	[ ]	[ ]			

Have you any disease, condition, or problem not previously listed?_____

DENTAL HEALTH

When was your last dental visit? _____

How often did you see your dentist? _____

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

Do any of the following cause tooth discomfort? Hot_____ Cold_____ Sweets_____ Chewing_____

How often do you brush your teeth?_____ Floss?_____ Water jet?_____

Do your gums bleed when you brush or floss? _____ feel tender or swollen? _____

Have you had periodontal treatment?_____ When?_____

Do you clench or grind your teeth? _____

Do your jaws ever feel tired or ache? _____ Click or pop?_____

Can you chew on both sides of your mouth? _____ Comfortably?_____

Do you have frequent headaches? _____ Earaches?_____

Have you ever had orthodontic treatment (braces)?_____ When?_____

Do you lose fillings or break fillings?_____ Do you usually have many cavities?_____

Do you have any loose teeth? _____ Cracked or broken teeth?_____

Do you have any noticeable wear on your teeth? _____ Food traps?_____

Do you have any missing teeth?_____ Have they been replaced?_____

If so, how? Fixed bridge_____ Removable partial_____ Full denture_____ Dental implant_____

Are you comfortable with the replacement? _____ Please describe_____

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

Have you ever had any cosmetic dentistry done to improve your appearance?_____

If yes, are you pleased with the result? _____ Please comment_____

_____

Have you ever had any unpleasant dental experience? _____

Please add anything you feel is important: _____

_____

_____

"I understand that should there be a change in my health during my dental treatment, I am to inform the dentist at the earliest possible time."

Signature_____ Date_____

Reviewed and discussed with the patient by J. Ladd Williams, D.D.S. _____
Doctor's Signature

DENTAL INSURANCE [ ] YES [ ] NO

Name of Carrier: _____ Group #: _____

Person responsible for this account: _____ Relationship: _____

Social Security Number: _____ I.D. number (if different): _____

Date of Birth: _____ Employed by: _____

Employer's Address: _____ Phone #: _____