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__________

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Have you ever had any unpleasant dental experience? ___________

Please add anything you feel is important: ___________

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"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 #: __________