

CONFIDENTIAL PATIENT HEALTH RECORD

NAME: _____ D.O.B. _____ Home Phone _____
(Last) (First) (Middle)

Address: _____ SSN: _____ / _____ / _____
(Street) (City) (State) (Zip)

Check appropriate box: Minor Single Married Divorced Widowed Separated

RESPONSIBLE PARTY: _____ Relationship to Patient: _____

D.O.B.: _____ Driver License # _____ SSN: _____ / _____ / _____

Address _____ Home Phone: _____

Name / Address of Nearest Relative: _____ Phone: _____
(In Case of Emergency)

Your E-Mail Address _____ Referred By: _____

MEDICAL HEALTH

General health (please check): EXCELLENT GOOD FAIR POOR Last complete physical _____

Name and address of physician _____ Phone: _____

Are you taking any medication now? Yes No For what purpose? _____

Which medications? _____

Do you require antibiotics before routine dental treatment? Yes No

Have you ever been treated (other than diagnostic) with radiation? Yes No Fen-Phen / Redux Yes No

Are you allergic to: Penicillin Codeine Local injected anesthetics Latex Other _____

Women: Are you pregnant? Yes No How long? _____ (months)

Advisory: Antibiotics may render birth control medications ineffective.

Have you ever been treated for:

Heart disease Yes <input type="checkbox"/> No <input type="checkbox"/>	Tuberculosis or lung disease Yes <input type="checkbox"/> No <input type="checkbox"/>	Sinus trouble Yes <input type="checkbox"/> No <input type="checkbox"/>
Rheumatic fever. Yes <input type="checkbox"/> No <input type="checkbox"/>	Diabetes. Yes <input type="checkbox"/> No <input type="checkbox"/>	Arthritis Yes <input type="checkbox"/> No <input type="checkbox"/>
High/Low Blood Pressure . Yes <input type="checkbox"/> No <input type="checkbox"/>	Epilepsy/Convulsions . . . Yes <input type="checkbox"/> No <input type="checkbox"/>	Stroke Yes <input type="checkbox"/> No <input type="checkbox"/>
Angina / Chest Pain Yes <input type="checkbox"/> No <input type="checkbox"/>	Fainting/Seizures Yes <input type="checkbox"/> No <input type="checkbox"/>	Glaucoma Yes <input type="checkbox"/> No <input type="checkbox"/>
Heart Murmur Yes <input type="checkbox"/> No <input type="checkbox"/>	Sexually transmitted diseases Yes <input type="checkbox"/> No <input type="checkbox"/>	Joint Replacement / Implant Yes <input type="checkbox"/> No <input type="checkbox"/>
Cardiac Pacemaker Yes <input type="checkbox"/> No <input type="checkbox"/>	AIDS or HIV Infection . . . Yes <input type="checkbox"/> No <input type="checkbox"/>	Leukemia Yes <input type="checkbox"/> No <input type="checkbox"/>
Anemia Yes <input type="checkbox"/> No <input type="checkbox"/>	Hepatitis/Jaundice Yes <input type="checkbox"/> No <input type="checkbox"/>	Cancer Yes <input type="checkbox"/> No <input type="checkbox"/>
Congenital Heart Lesions . Yes <input type="checkbox"/> No <input type="checkbox"/>	Liver Disease Yes <input type="checkbox"/> No <input type="checkbox"/>	Prolonged Bleeding Yes <input type="checkbox"/> No <input type="checkbox"/>
Ulcers/Stomach troubles . Yes <input type="checkbox"/> No <input type="checkbox"/>	Kidney Disease Yes <input type="checkbox"/> No <input type="checkbox"/>	Thyroid problems Yes <input type="checkbox"/> No <input type="checkbox"/>
	Asthma or hay fever. Yes <input type="checkbox"/> No <input type="checkbox"/>	Infectious/contagious disease Yes <input type="checkbox"/> No <input type="checkbox"/>

INFORMED CONSENT

1. I am responsible for ALL charges related to services provided to me at the usual and customary charges of the dental office.
2. I hereby grant authority to the dentist(s) in charge of my care to administer any treatment, anesthetics or drugs and to perform such operations as may be deemed necessary in the diagnosis and treatment of my case. I acknowledge that I have been informed of the risks, benefits, alternatives and possible consequences of the treatment proposed and I authorize the treatment.
4. Dental treatment may include examination, X-rays, cleaning, gum disease treatment, fillings, root canals and prosthodontics usually with local anesthesia. If the cavity in the tooth is very deep, the removal of the nerve or the tooth may be necessary. We would like to provide you with complete information regarding the risks and benefits of your dental treatment.
3. I was provided with THE DENTAL MATERIALS FACT SHEET as required by California Law. I also understand that The Fact Sheet would be provided to me anytime in the future upon my request.

Signed X _____ Date _____

Signature of Patient or Parent if minor

(Continue other side)

DENTAL HEALTH

Reason for visit: _____ When was your last dental visit? _____

Prior dentist name: _____ What was last treatment? _____

Have you ever had any serious medical problem associated with previous dental treatment? Yes No

If so, explain: _____

How often do you brush your teeth? _____

What texture brush do you use? SOFT MEDIUM HARD NYLON NATURAL

Do you floss daily? Yes No Do your gums bleed while brushing or flossing? Yes No

Do you feel twinges of pain when your teeth come in contact with: Hot Cold Sweets Sours

Do you chew on only one side of your mouth? Yes No If yes, explain: _____

Do your gums feel tender or swollen? Yes No Do you clench or grind your jaws while sleeping or during the day? Yes No

Do your jaws ever feel tired? Yes No Do your jaws "pop" or "click"? Yes No

Would you like to change anything about your smile? Yes No

Explain: _____

Please add anything you feel is important: _____

INSURANCE INFORMATION

Name of Insured _____ Relationship to patient _____

Employer _____ Address _____ Work Phone _____

Insurance Company _____ GROUP# _____

Additional Insurance Yes No

Name of Insured _____ Relationship to patient _____

Employer _____ Address _____ Work Phone _____

Insurance Company _____ GROUP# _____

If patient is a student, Name of School/College _____

I, the undersigned, hereby authorize the release of any information including the diagnosis and the records of any treatments or examinations rendered, to my insurance company or companies. This release is solely for the purpose of facilitating the billing and reimbursement, directly to the Dental Provider, of insurance benefits under which I am entitled.

X

_____ DATE

_____ SIGNED

ANNUAL MEDICAL HISTORY UPDATES

I have reviewed the attached MEDICAL HISTORY. My (or the patient's) health information has changed as follows (if no change, write "NO CHANGE"): _____

X

_____ Signature of Patient (or Guardian)

_____ Date

_____ Update reviewed by Dr.

I have reviewed the attached MEDICAL HISTORY. My (or the patient's) health information has changed as follows (if no change, write "NO CHANGE"): _____

X

_____ Signature of Patient (or Guardian)

_____ Date

_____ Update reviewed by Dr.

I have reviewed the attached MEDICAL HISTORY. My (or the patient's) health information has changed as follows (if no change, write "NO CHANGE"): _____

X

_____ Signature of Patient (or Guardian)

_____ Date

_____ Update reviewed by Dr.