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PATIENT HEALTH RECORD

Date: ________________
Name: (Last) ______________________________ (First) __________________________(Middle Initial) _____
Home Address: (Street) ____
(City)____ (Zip) __________________________________
(Phone Number)_________________________ Email Address: ______________________________________
Date of Birth: _________________________ Sex: _______ Height: _______________Weight:______________
Your Social Security Number: _______________________________
Marital Status: Single________ Married________ Widowed_______ Divorced________
If married, spouse's name: _______________________________________
Your Occupation: ___________________________ Employer: ______________________________________
Insured D.O.B.:______________________________ Insured Employer: ________________________________
Dental Insurance Company: ______________________Name of Insured Employee: ______________________
Insured Social Security Number: ___________________ Group No.:___________________________________
I.D. No.:__________________________________ Referred by: ______________________________________

MEDICAL HEALTH

General Health: Excellent _________ Good_________ Fair__________ Poor__________
Name and Address of Physician:
____
Date of Last Physical : _________________________________
Are you taking any medications now? Yes______ No_______
List Meds:
____
____
Cannabis: Medical or Recreational__________________________________
Do you smoke/vape/e cigarettes?_________ Yes No How much?__________________________________
Are you presently being treated for or have you been treated for:

Heart Disease________________________	Yes	No	Any Communicable Diseases _________	Yes	No
Abnormal Blood Pressure_______________	Yes	No	Ulcers ____________________________	Yes	No
Asthma or Hay Fever__________________	Yes	No	Tuberculosis or Lung Disease__________	Yes	No
Sinus Trouble_________________________	Yes	No	Diabetes ___________________________	Yes	No
Cough______________________________	Yes	No	Epilepsy___________________________	Yes	No
Hepatitis____________________________	Yes	No	Anemia____________________________	Yes	No
Arthritis____________________________	Yes	No	Stroke_____________________________	Yes	No
Glaucoma___________________________	Yes	No	AIDS/HIV__________________________	Yes	No

Are you taking a blood thinner and/or routine aspirin or fish oil?______________________________ Yes No
If yes which one(s)? ____

Are you allergic to: Penicillin__________ Codeine___________ Local Anesthetics__________
Other Medications ____

Are you currently under cancer or radiology treatment?_____________________________________Yes No
Are you subject to prolonged bleeding?____Yes No
Are you subject to fainting spells?____ Yes No
Are you currently pregnant?____ Yes No
Have you been vaccinated for Covid-19?____ Yes No
If yes, expected delivery date:______________________________
Have you ever been hospitalized?____ Yes No
If so, When?_____________________________ Why?____
____

____
Have you had any outpatient surgery? If so when, and what was done?
____

DENTAL HEALTH

Reason for visit: ____
When was your last dental visit?____
Have you ever had a serious problem associated with previous dental treatment?________________ Yes No
If so, explain____
How often do you brush your teeth?____
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 you gag easily?____ Yes No
Please add anything you feel is important:
____
____

Patient Signature: ____

Emergency Contact Name and Number: ____