PATIENT HEALTH RECORD

In order to help me render proper dental services to you, would you please be kind enough to answer the following questions.

NAME **DATE OF BIRTH**

SEX **OCCUPATION** **SOCIAL SECURITY NUMBER**

ADDRESS **CITY** **ZIP CODE**

HOME PHONE **CELL PHONE** **BUSINESS PHONE**

EMERGENCY CONTACT NAME AND PHONE NUMBER

HOW DID YOU HEAR ABOUT OUR OFFICE?

NAME OF DENTAL INSURANCE (IF APPLICABLE) **IDENTIFICATION/SUBSCRIBER NUMBER**

SUBSCRIBER'S NAME **SUBSCRIBER'S DATE OF BIRTH**

MEDICAL HEALTH

ARE YOU CURRENTLY TAKING ANY MEDICATION? YES _____ NO_____ **(PLEASE USE BACK OF SHEET IF NEEDED)**
IF YES, FOR WHAT PURPOSE?_____

HAVE YOU EVER BEEN DIAGNOSED OR TREATED FOR:

HEART DISEASE----------YES_____ NO_____ HEART MURMUR---------- YES_____ NO_____
RHEUMATIC FEVER--------- YES_____ NO_____ JAUNDICE---------- YES_____ NO_____
ABNORMAL BLOOD PRESSURE YES_____ NO_____ ASTHMA/HAY FEAVER------- YES_____ NO_____
ULCERS---------- YES_____ NO_____ SINUS TROUBLE---------- YES_____ NO_____
TUBERCULOSIS/LUNG DISEASE YES_____ NO_____ COUGH---------- YES_____ NO_____
DIABETES---------- YES_____ NO_____ HEPATITIS---------- YES_____ NO_____
EPILEPSY---------- YES_____ NO_____ ARTHRITIS---------- YES_____ NO_____
ANEMIA---------- YES_____ NO_____ STROKE---------- YES_____ NO_____
CONGENITAL HEART LESIONS-- YES_____ NO_____ GLAUCOMA---------- YES_____ NO_____
ANY JOINT REPLACEMENTS----- YES_____ NO_____ HIV POSITIVE---------- YES_____ NO_____
ARE YOU ALLERGIC TO: PENICILLIN_____ CODEINE_____ LOCAL INJECTED ANESTHETICS_____
OTHER ALLERGIES:_____
ARE YOU SUBJECT TO FAINTING SPELLS? YES____ NO____ If yes, please explain_____
ARE YOU SUBJECT TO PROLONGED BLEEDING? YES____ NO____
(WOMEN) ARE YOU PREGNANT? YES____ NO____

PLEASE SIGN **DATE**