

**Patient Health Record**

Date \_\_\_\_\_  
Name(last, first, middle initial) \_\_\_\_\_  
Address(street,apt.#,city,state,zip code) \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Your Social Security Number \_\_\_\_\_  
Marital Status(circle one):    single            married  
Spouse's Name \_\_\_\_\_  
Your Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Name and address of Dental Insurance Co: \_\_\_\_\_

Insured person's name (ex: you, spouse/parent's name) \_\_\_\_\_  
Insured person's social security number \_\_\_\_\_  
Dental Insurance Group or Account Number \_\_\_\_\_  
Referred by \_\_\_\_\_

**Dental Health**

When was your last dental exam/cleaning? \_\_\_\_\_  
Have you had any serious problems with dental treatment? Please explain if so.

\_\_\_\_\_  
\_\_\_\_\_

Are you having any pain/problems at this time? \_\_\_\_\_

Do your gums bleed when you brush or floss?    Yes    No  
Have you lost any teeth?    Yes    No    If yes, when? \_\_\_\_\_  
Are you having any TMJ problems (clicking or pain in the jaw muscle)?    Yes    No  
Would you like to change the shape or alignment of your teeth?    Yes    No  
Would you like to have whiter teeth?    Yes    No  
Why did you leave your last dentist? \_\_\_\_\_

**Financial Policies**

Once you have provided our office with your current dental insurance information, we will be happy to file all necessary claims for you at no extra charge. However, the patient needs to realize that the insurance agreement is between the insurance company and the patient and not with the doctor. We request those patients with insurance to pay their respective co-payments at the time of treatment. If there is a balance after insurance responds the patient is required to pay that amount.

Patients not having dental insurance will be required to pay for services when treatment is rendered. For cases requiring multiple visits, 1/2 of the total fee will be due at the initial visit. Full payment must be made at completion of treatment unless other arrangements have been made.

A 24 hour notice is required to cancel or reschedule an appointment or there will be a \$50 fee.

Please understand that if payment is not made when due, the account may be turned over for collections. You will be responsible for any and all costs associated with the collection procedure, including but not limited to billing costs, collection fees, lawyer's fees, and court costs.

NAME \_\_\_\_\_ DATE \_\_\_\_\_



**Medical Record**

Are you currently under the care of a physician? . . . . . yes no

If yes, name of physician? \_\_\_\_\_

For what reason? \_\_\_\_\_

Have you ever been treated for any of the following?

Hepatitis, jaundice, or liver disease . . . . . yes no

Tuberculosis or lung disease . . . . . yes no

Congenital heart lesions . . . . . yes no

Damaged/artificial heart valves . . . . . yes no

Heart murmur . . . . . yes no

HIV/AIDS . . . . . yes no

Rheumatic fever . . . . . yes no

Cardiovascular disease (heart attack, stroke, arteriosclerosis, coronary occlusion, pacemaker, high blood pressure) – please circle all that apply . . . . . yes no

Artificial joint replacement . . . . . yes no

Allergy/hay fever . . . . . yes no

Sinus trouble . . . . . yes no

Asthma . . . . . yes no

Diabetes . . . . . yes no

Epilepsy/seizures . . . . . yes no

Cancer . . . . . yes no

Psychiatric problems . . . . . yes no

Ulcers . . . . . yes no

Arthritis . . . . . yes no

Anemia . . . . . yes no

Glaucoma . . . . . yes no

Fainting spells . . . . . yes no

Kidney trouble . . . . . yes no

Are you allergic to penicillin, codeine, aspirin, local anesthetics? (circle) . yes no

Other medicines \_\_\_\_\_

Are you currently taking any medications? . . . . . yes no

If yes, what medication & why? \_\_\_\_\_

Women: are you pregnant? . . . . . yes no

If yes, expected due date \_\_\_\_\_

Are you subject to prolonged bleeding? . . . . . yes no

Do you have any condition/problem/disease that we should know about? . yes no

If yes, please explain \_\_\_\_\_

**Signature** \_\_\_\_\_

Medical History update: \_\_\_\_\_

Medical History update: \_\_\_\_\_

Medical History update: \_\_\_\_\_

Medical History update: \_\_\_\_\_