

PATIENT HEALTH RECORD

Date _____

Welcome to our office. We will do our best to make your appointments as convenient and pleasant as possible. If at any time you have any questions regarding your treatment, your appointment, or fees, please feel free to ask. This acquaintance form will help us serve you better.

Name _____ Social Security # _____
(Last) (First) (Middle)

Street Address _____ City _____ State/Zip _____ Phone # _____

Mailing Address _____ City _____ State/Zip _____ Cell # _____

Employer _____ Occupation _____

Business Address _____ City _____ State/Zip _____ Phone # _____

Date of Birth _____ Gender M / F _____ Height _____ Weight _____ Referred by _____

Marital Status (check) Single _____ Married _____ Widowed _____ Divorced _____

Spouse's Name _____ Date of Birth _____ Social Security # _____

Spouse Employed by _____ Address _____

Type of Dental Insurance (If applicable) _____ Policy # _____

DENTAL HEALTH

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

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

If Yes, explain: _____

Yes No Is there any condition you feel your dentist should know about before undertaking treatment?

Please Describe _____

Yes No Do you clench or grind your jaws while sleeping or during the day?

Yes No Have you ever had a reaction to a dental injection?

Yes No Do your gums feel tender or swollen?

Yes No Do your jaws ever feel tired?

Yes No Do you smoke or use smokeless tobacco?

Yes No Do you have difficulty swallowing?

Yes No Have you noticed a change in the way your voice sounds?

Yes No Do you have any swelling in your jaw or neck?

All professional fees are due when services are rendered. If you are covered by a dental insurance plan, your percentage of fees and deductible must be paid at time of service.

Patient's Signature: _____

Eaglesoft Medical History(Custom)(3)

Patient Name:

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Have you ever been hospitalized or had a major operation? Have you ever had a serious head or neck injury? Do you take, or have you taken, Phen-Fen or Redux? Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Are you on a special diet? Do you smoke or use smokeless tobacco? Do you use controlled substances?

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Sulfa Drugs Local Anesthetics

Are you currently taking any medications? If yes, name medication and purpose.

Do you have, or have you had, any of the following?

AIDS/HIV Positive Alzheimer's Disease Anaphylaxis Anemia Angina Arthritis/Gout Artificial Heart Valve Artificial Joint Asthma Blood Disease Blood Transfusion Breathing Problems Bruise Easily Cancer Chemotherapy Chest Pains Cold Sores/Fever Blisters Congenital Heart Disorder Convulsions Yellow Jaundice Cortisone Medicine Diabetes Drug Addiction Easily Winded Emphysema Epilepsy or Seizures Excessive Bleeding Excessive Thirst Fainting Spells/Dizziness Frequent Cough Frequent Diarrhea Frequent Headaches Genital Herpes Glaucoma Hay Fever Heart Attack/Failure Heart Murmur Heart Pacemaker Heart Trouble/Disease Taking a blood thinner Hemophilia Hepatitis A Hepatitis B or C Herpes High Blood Pressure High Cholesterol Hives or Rash Hypoglycemia Irregular Heartbeat Kidney Problems Leukemia Liver Disease Low Blood Pressure Lung Disease Mitral Valve Prolapse Osteoporosis Jaw pain / grinding Parathyroid Disease Psychiatric Care Infective endocarditis Radiation Treatments Recent Weight Loss Renal Dialysis Rheumatic Fever Rheumatism Scarlet Fever Shingles Sickle Cell Disease Sinus Trouble Spina Bifida Stomach/Intestinal Disease Stroke Swelling of Limbs Thyroid Disease Tonsillitis Tuberculosis Tumors or Growths Ulcers Venereal Disease

Have you ever had any serious illness not listed above? If yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X _____

Date: _____