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 #_____

MEDICAL HEALTH

Name of physician_____ Month/Year of last complete physical_____

Are you currently taking any medication ? Y / N If YES, name medication and purpose:_____

_____

Do you have now or have you ever been treated for:

Yes ☐ No ☐ Abnormal Blood Pressure
Yes ☐ No ☐ Acquired Immune Deficiency Syndrome (AIDS)
Yes ☐ No ☐ Anemia
Yes ☐ No ☐ Asthma or hay fever
Yes ☐ No ☐ Carcinoma (cancer)
Yes ☐ No ☐ Cardiovascular disease
Yes ☐ No ☐ Cough
Yes ☐ No ☐ Congenital heart lesions
Yes ☐ No ☐ Diabetes
Yes ☐ No ☐ Epilepsy
Yes ☐ No ☐ Heart disease
Yes ☐ No ☐ Hepatitis
Yes ☐ No ☐ Infective endocarditis
Yes ☐ No ☐ Do you have an artificial heart valve?
Yes ☐ No ☐ Liver disease
Yes ☐ No ☐ Osteoporosis
Yes ☐ No ☐ Stroke
Yes ☐ No ☐ Tuberculosis or lung disease
Yes ☐ No ☐ Do you have fainting spells?
Yes ☐ No ☐ Ulcers
Yes ☐ No ☐ Venereal disease (bad blood)
Yes ☐ No ☐ Do you take a blood thinner?
Yes ☐ No ☐ Do you have an artificial joint?
Yes ☐ No ☐ Do you have a pacemaker?

Are you ALLERGIC to any of these?

Yes ☐ No ☐ Aspirin
Yes ☐ No ☐ Codeine
Yes ☐ No ☐ Local injected anesthetics
Yes ☐ No ☐ Penicillin
Yes ☐ No ☐ Sulfa
Yes ☐ No ☐ Latex Allergy
Yes ☐ No ☐ Other Medications?

Yes ☐ No ☐ Are you subject to prolonged bleeding spells?
Yes ☐ No ☐ Have you ever been treated with chemo or radiation therapy?
Yes ☐ No ☐ Are you pregnant? If YES, how long? _____
Yes ☐ No ☐ Do you pre-medicate before dental treatment? If YES, why ?_____

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:_____

How would you prefer to be notified of upcoming dental appointments?
Text / Phone Call #

CHILDREN'S 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.

Child's Name_____ Social Security #_____
(Last) (First) (Middle)

Home Address_____ City_____ State/Zip_____ Phone #_____

Date of Birth (DOB)_____ Gender M / F____ Height_____ Weight_____ Referred by_____

Father's Name_____ DOB_____ Cell #_____ Social Security #_____

Father's Address_____ City_____ State/Zip_____ Phone #_____

Father Employed By_____ Address_____ Phone #_____

Mother's Name_____ DOB_____ Cell #_____ Social Security #_____

Mother's Address_____ City_____ State/Zip_____ Phone #_____

Mother Employed By_____ Address_____ Phone #_____

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

MEDICAL HEALTH

Name of physician_____ Month/Year of last complete physical_____

Are you currently taking any medication? Y / N If YES, name medication and purpose:_____

_____

Do you have now or have you ever been treated for:

Yes ☐ No ☐ Abnormal Blood Pressure
Yes ☐ No ☐ Acquired Immune Deficiency Syndrome (AIDS)
Yes ☐ No ☐ Do you have a pacemaker?
Yes ☐ No ☐ Asthma or hay fever
Yes ☐ No ☐ Carcinoma (cancer)
Yes ☐ No ☐ Cardiovascular disease
Yes ☐ No ☐ Cough
Yes ☐ No ☐ Congenital heart lesions
Yes ☐ No ☐ Diabetes
Yes ☐ No ☐ Epilepsy
Yes ☐ No ☐ Do you have an artificial heart valve?
Yes ☐ No ☐ Have you ever been treated with chemo or radiation therapy?
Yes ☐ No ☐ Are you pregnant? If YES, how long? _____
Yes ☐ No ☐ Do you pre-medicate before dental treatment? If YES, why?_____

Yes ☐ No ☐ Heart disease
Yes ☐ No ☐ Hepatitis
Yes ☐ No ☐ Infective endocarditis
Yes ☐ No ☐ Are you subject to prolonged bleeding spells?
Yes ☐ No ☐ Liver disease
Yes ☐ No ☐ Osteoporosis
Yes ☐ No ☐ Stroke
Yes ☐ No ☐ Tuberculosis or lung disease
Yes ☐ No ☐ Ulcers
Yes ☐ No ☐ Venereal disease (bad blood)
Yes ☐ No ☐ Do you have fainting spells?

Yes ☐ No ☐ Do you take a blood thinner?
Yes ☐ No ☐ Do you have an artificial joint?
Yes ☐ No ☐ Anemia

Are you <u>ALLERGIC</u> to any of these?
Yes ☐ No ☐ Aspirin
Yes ☐ No ☐ Codeine
Yes ☐ No ☐ Local injected anesthetics
Yes ☐ No ☐ Penicillin
Yes ☐ No ☐ Sulfa
Yes ☐ No ☐ Latex Allergy
Yes ☐ No ☐ Other medications?

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?

How would you prefer to be notified of upcoming dental appointments?
Text / Phone Call #_____
Email

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.

NOTE: We do not bill absent parents. The adult presenting the minor for care is the responsible party.