PATIENT HEALTH RECORD #_____

In order to help us render the proper dental services to you, would you please be kind enough to answer the following questions. Please note the Space for remarks for any answers that require clarification or any other information you think we should have. Thank you for your cooperation.

Date: _____ Patient Name: _____
(LAST) (FIRST) (MIDDLE)

Address: _____, _____, _____, _____ HM Phone: (____)_____-_____
(STREET) (CITY) (STATE) (ZIP)

Sex: M / F. Date of Birth: ____/____/____ Marital Status: ____Cell:(____)_____-_____Social Security #_____/ _____/_____

Patient Email Address _____Patient Driver's License #: _____

Insured's Name: _____Insured's Date of birth ____/____/_____ Social Security # _____/_____/_____

Insured's Employer: _____Co. Address: _____ Phone: (____)_____-_____

Insured's Spouse's Employer: _____Co. Address: _____Phone (____)_____-_____

Do You Have Dental Insurance? YES / NO Insurance Company: _____ Ins. ID. No._____

Responsible Party: _____Address: _____ Phone: (____)_____-_____

Name/Address of Other Nearest Relative: _____ Phone: (____)_____-_____

Whom may we thank for the referral _____Do you have: Facebook ☐Yes ☐No Yelp ☐Yes ☐No

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DENTAL HISTORY

☐Yes ☐No	Bleeding Gums	☐Yes ☐No	Have You Ever Had Gum Treatments
☐Yes ☐No	Bad Taste, Odor or Breath	☐Yes ☐No	Pack Food Between Your Teeth
☐Yes ☐No	Tooth Sensitive To Hot, Cold, Sweet, Bite	☐Yes ☐No	Pain or Noise in Your Jaw Joint
☐Yes ☐No	Loose Teeth	☐Yes ☐No	Burning Tongue Feeling
☐Yes ☐No	Gum Boil or Abscess	☐Yes ☐No	Orthodontic Treatment
☐Yes ☐No	Trench Mouth	☐Yes ☐No	Prolonged Bleeding After Extraction
☐Yes ☐No	Canker Sores or Cold Sores	☐Yes ☐No	Adverse Reaction To Dental Anesthetic
☐Yes ☐No	Breath Through Your Mouth	☐Yes ☐No	Grind or Clench Your Teeth at Night/Day

When Were Your Teeth Last Cleaned in a Dental Office? _____
Do You Use:
☐ Manual Toothbrush ☐ Electric Toothbrush ☐ Dental Floss ☐ Water Pik Other:_____
How Often Do You: Brush? _____ Times per Day Floss? _____ Times per Day

INFORMED CONSENT

1. **We will gladly process your insurance claim; estimate your deductible and the patient portion not covered by your insurance. The estimated amount not covered by your insurance is due at the time of your treatment. Our estimate is subject to final approval by your insurance. Therefore, the amount due is subject to change.**
2. **Payment Options: Please check one. Cash___ Check___ Credit Card___ (Visa, Discover, American Express, MasterCard) Finance monthly payments through CARE CREDIT (please ask the receptionist for information or application)**
3. **I understand that I am financially responsible for any charges not covered by insurance.**
4. **I understand a fee applies to appointments missed or cancelled with out 24 hours notice.**
5. **I understand there will be a $5.00 billing charge each month for unpaid balances.**
6. **I hereby grant authority to: The Dental Group and/or the dentist(s) in charge of my care, to administer any treatment, to administer such anesthetics or drugs, and to perform such operations as may be deemed necessary in the diagnosis and treatment of my case, I acknowledge that I have been informed of the risks and possible consequences of the operation proposed and do authorize the above doctor(s) to proceed.**

SIGNED_____

Patient or nearest relative in the case when the patient is a minor or physically or mentally incompetent.

----OVER-----

MEDICAL HISTORY

PATIENT NAME _____**Birth Date** _____**Date**_____
General Health (Please Check): ☐**Excellent** ☐**Good** ☐**Fair** ☐**Poor** **Date of Last Complete Physical:**____/____/_____

Name of Physician: _____**Address:** _____**Phone:** (___)_____-_____

Are You Taking Any Medications? ☐**Yes** ☐**No**

Have You Taken or Are You Now Taking:

__**Nitroglycerine** __**Insulin**
__**Anticoagulants** __**Digitalis**
__**Tranquilizers** __**Cortisone**
__**Phen Phen** __**Coumadin**
__**Drugs for Blood Pressure**
__**Fosomax/Osteoperodic Medicine**

Please List All Medications You Are Taking:	For What Reason:

ARE YOU ALLERGIC TO OR EVER HAD A REACTION TO:

☐**Yes** ☐**No** **Penicillin**
☐**Yes** ☐**No** **Codeine**
☐**Yes** ☐**No** **Local Injected Anesthetic**
☐**Yes** ☐**No** **Sulfa Drugs**
☐**Yes** ☐**No** **Other:**_____
☐**Yes** ☐**No** **Aspirin**
☐**Yes** ☐**No** **Erythromycin**
☐**Yes** ☐**No** **Valium**
☐**Yes** ☐**No** **Latex**

☐**Yes** ☐**No** **Do You Require Antibiotics for Routine Dental Treatment? Name of Antibiotic:** _____ **Dose:** _____
*Women Advisory: Antibiotics may render birth control medications ineffective.

Do You Have Or Have You Ever Been Treated For Any Of The Following:

☐**Yes** ☐**No** **Major Operation:**_____
☐**Yes** ☐**No** **Heart Disease:**_____
☐**Yes** ☐**No** **Heart By-Pass Surgery:**_____
☐**Yes** ☐**No** **Heart Attack: When:**_____
☐**Yes** ☐**No** **Chest Pains**
☐**Yes** ☐**No** **Stroke: When:**_____
☐**Yes** ☐**No** **Congenital Heart Lesions**
☐**Yes** ☐**No** **Heart Murmur / Mitral Valve Prolapse**
☐**Yes** ☐**No** **Rheumatic Fever**
☐**Yes** ☐**No** **Abnormal Blood Pressure-High: ____Low:____**
☐**Yes** ☐**No** **Diabetes: _____Self _____Family Member**
☐**Yes** ☐**No** **Hepatitis or Jaundice Type:**_____
☐**Yes** ☐**No** **Tuberculosis or Lung Disease**
☐**Yes** ☐**No** **Thyroid Problems: Type:**_____
☐**Yes** ☐**No** **Kidney or Liver Disease/Infection**
☐**Yes** ☐**No** **Cancer: Type**_____
☐**Yes** ☐**No** **Radiation or Chemotherapy:**_____
☐**Yes** ☐**No** **Cardiac Pacemaker**
☐**Yes** ☐**No** **Sinus Trouble**
☐**Yes** ☐**No** **Serious Illness**_____
☐**Yes** ☐**No** **A.I.D.S. or Exposed to AIDS**
☐Yes ☐No **HIV Positive/High Risk Activity**
☐**Yes** ☐**No** **Venereal Disease**
☐**Yes** ☐**No** **Herpes Infection**
☐**Yes** ☐**No** **Immune Deficiency Disease: Type:**_____
☐**Yes** ☐**No** **Lymes Disease or Multiple Sclerosis**
☐**Yes** ☐**No** **Lupus or Chronic Fatigue Syndrome**
☐**Yes** ☐**No** **Epilepsy or Convulsions**
☐**Yes** ☐**No** **Any Infectious/Contagious Disease**
☐**Yes** ☐**No** **Cough**
☐**Yes** ☐**No** **Anemia**
☐**Yes** ☐**No** **Stomach Ulcers or Problems**
☐**Yes** ☐**No** **Arthritis**
☐**Yes** ☐**No** **Hypoglycemia/Hyperglycemia**
☐**Yes** ☐**No** **Asthma or Trouble Breathing**
☐**Yes** ☐**No** **Joint Replacement or Implant: Type**_____
☐**Yes** ☐**No** **Glaucoma**
☐**Yes** ☐**No** **Other**_____

DO YOU HAVE ANY OF THE FOLLOWING:

☐**Yes** ☐**No** **Swollen Ankles, Feet or Hands**
☐**Yes** ☐**No** **Bleeding Tendency or Bruise Easily**
☐**Yes** ☐**No** **Do You Have Excessive Urination/Thirst?**
☐**Yes** ☐**No** **Severe or Frequent Headaches**
☐**Yes** ☐**No** **Dizziness or Fainting Spells**
☐**Yes** ☐**No** **Psychiatric Care or Therapy**
☐**Yes** ☐**No** **Drug Rehabilitation or Alcoholism**
☐**Yes** ☐**No** **Often Under Stress or Tension**
☐**Yes** ☐**No** **Nervousness**
☐**Yes** ☐**No** **Hormone Problems**
☐**Yes** ☐**No** **Have You Reached Menopause?**
☐**Yes** ☐**No** **Do You Smoke? How Many? _____ per Day**
☐**Yes** ☐**No** **Do You Drink Alcoholic Beverages?**
☐**Yes** ☐**No** **Are You Pregnant? How Many Months?**_____

SIGNED _____**Patient or nearest relative in the case patient is a minor or physically incompetent.**

MEDICAL HISTORY REVIEWED BY _____ **DATE:** _____
SIGNATURE

HISTORY UPDATE	INITIAL/DATE	INITIAL/DATE	INITIAL/DATE	INITIAL/DATE	INITIAL/DATE	INITIAL/DATE
REVIEWED BY:						
PATIENT/GUARDIAN						

----OVER-----