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: _____, _____, _____, _____ Cell # (____)_____-_____
(STREET) (CITY) (STATE) (ZIP)
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: (____)_____-_____

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

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DENTAL HISTORY

☐Yes ☐No Have You Ever Had Gum Treatments ☐Yes ☐No Tooth Sensitive To Hot, Cold, Sweet, Bite
☐Yes ☐No Pain or Noise in Your Jaw Joint ☐Yes ☐No Grind or Clench Your Teeth at Night/Day
When Were Your Teeth Last Cleaned in a Dental Office? _____

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 without 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** _____ **Sex: M / F** **Date** _____

Are you under a physician's care now?

☐**Yes** ☐**No** **If yes Name of Physician:** _____ **Phone: (___)_____-_____**

Have You Ever Been hospitalized or had a major operation: ☐**Yes** ☐**No If yes**_____

Are You Taking Any Medications? ☐**Yes** ☐**No If yes , please list in the next section**

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:**

☐**Yes** ☐**No** **Do You Smoke or use Tobacco?** *If yes*_____

☐**Yes** ☐**No** **Do You use controlled substances?** *If yes*_____

Women: Are you.....

☐**Yes** ☐**No** **Are You Pregnant? How Many Months?_____** ☐**Yes** ☐**No** **Nursing**

☐**Yes** ☐**No** **Taking contraceptives?** *Women Advisory: Antibiotics may render birth control medications ineffective.

ARE YOU ALLERGIC TO OR EVER HAD A REACTION TO:

☐**Yes** ☐**No** **Penicillin**
☐**Yes** ☐**No** **Codeine**
☐**Yes** ☐**No** **Local Injected Anesthetic**
☐**Yes** ☐**No** **Latex**
☐**Yes** ☐**No** **Aspirin**
☐**Yes** ☐**No** **Metal or Acrylic**
☐**Yes** ☐**No** **Sulfa Drugs**
☐**Yes** ☐**No** **Other** _____

☐**Yes** ☐**No** **Do You Require Antibiotics for Routine Dental Treatment? Name of Antibiotic:** _____ **Dose:** _____

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

☐**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** **Cardiac Pacemaker**
☐**Yes** ☐**No** **Heart Murmur / Mitral Valve Prolapse**
☐**Yes** ☐**No** **Joint Replacement, Valve or Implant: Type_____**
☐**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** **Leukemia or blood disease**
☐**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** **Lyme's Disease or Multiple Sclerosis**
☐**Yes** ☐**No** **Any Infectious/Contagious Disease**
☐**Yes** ☐**No** **Lupus or Chronic Fatigue Syndrome**
☐**Yes** ☐**No** **Epilepsy, Seizures or Convulsions**
☐**Yes** ☐**No** **Alzheimer's**
☐**Yes** ☐**No** **Sinus Trouble**
☐**Yes** ☐**No** **Anemia**
☐**Yes** ☐**No** **Stomach Ulcers or Problems**
☐**Yes** ☐**No** **Arthritis / Gout**
☐**Yes** ☐**No** **Hypoglycemia/Hyperglycemia**
☐**Yes** ☐**No** **Asthma or Trouble Breathing**
☐**Yes** ☐**No** **Glaucoma**
☐**Yes** ☐**No** **Other serious illness not listed above**_____

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** **Drug Rehabilitation or Alcoholism**
☐**Yes** ☐**No** **Psychiatric Care or Therapy**
☐**Yes** ☐**No** **Dizziness or Fainting Spells**
☐**Yes** ☐**No** **Do You Drink Alcoholic Beverages?** ***if yes how many and how often***_____

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-----