PATIENT HEALTH RECORD

Date:

...The following information is essential to provide you with quality dental health care... Thank you...

Name: (Last,First,Middle Initial)			Home Phone:	Work Phone:	Cell Phone:
Home Address:			City:	State:	Zip:
Age:	Birthdate:	E-mail Address:	Name of Physician:		

Have you had:

Check each box if the answer is "YES"; if "YES" explain below

- ☐ Rheumatic Heart Disease
- ☐ Heart Murmer
- ☐ Heart Attack / Surgery, Angina
- ☐ Anemia, Excessive Bleeding
- ☐ Irregular Heart Beat, Pacemaker
- ☐ Breathing Problems, Asthma, T.B.
- ☐ Cancer, Chemo / Radiation Therapy
- ☐ Diabetes
- ☐ Hepatitis, Jaundice, Liver Disease
- ☐ Abnormal Blood Pressure
- ☐ Artificial Joint Replacement
- ☐ Kidney Problems, Dialysis
- ☐ Stroke, Convulsions, Fainting
- ☐ Arthritis, Rhuematism
- ☐ Venereal Disease, A.I.D.S.
- ☐ Stomach or Intestinal Disease

Other health complications not listed above:

Have you ever had a major operation? If yes, describe.

Are you currently taking any medication? If yes, please list each medication and for what reason or condition?

Are you allergic to:

☐ Latex ☐ Penicillin ☐ Codeine ☐ Local Anesthetic ☐ Other Medications ____________

Authorization:

I authorize the dentist to release health information about me and information about my dental treatment to other health professionals and to insurance companies.

Person completing this form:

Signature:	Date:

If this form was not completed by the patient, please provide the following:

Printed name of person completing this form:	Relationship to patient: