CONFIDENTIAL PATIENT HEALTH RECORD

NAME:_____ D.O.B.:_____ SSN: ____/____/____
(Last) (First) (M.I.)

Address: _____ Home # _____
(Street)

_____ Cell # _____
(City) (State) (Zip)

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married

RESPONSIBLE PARTY:_____ Relationship to Patient: _____

D.O.B.:_____ Driver's License # _____ SSN: ____/____/____

Address:_____ Home Phone:_____

Name.Address of Nearest Relative: _____ Phone:_____
(In Case of Emergency)

Your E-mail Address: _____

MEDICAL HEALTH

General Health (please check): ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR Last physical exam _____

Are you taking any medications now? ☐YES ☐NO For what purpose?_____

Name of Physician:_____ Phone:_____

Address of Physician: _____

Which medications? _____

Do you require antibiotics before routine dental treatment? ☐YES ☐NO

Have you ever had any radiation therapy? ☐YES ☐NO Fen-Phen/Redux ☐YES ☐NO

Are you allergic to: ☐Penicillin ☐Codeine ☐Novacaine/Epinephrine ☐Latex ☐Other _____

Women: Are you pregnant? ☐Yes ☐No If yes, how long?_____(months)

Advisory: Antibiotics may render birth control medications ineffective.

Have you ever been treated for

Heart Disease	☐YES ☐NO	Thyroid Problems	☐YES ☐NO	Tuberculosis or Lung Disease	☐YES ☐NO
Rheumatic Fever	☐YES ☐NO	Diabetes	☐YES ☐NO	Sinus Trouble	☐YES ☐NO
High/Low Blood Pressure	☐YES ☐NO	Epilepsy/Seizures	☐YES ☐NO	Arthritis	☐YES ☐NO
Angina/Chest Pain	☐YES ☐NO	Fainting/Dizziness	☐YES ☐NO	Bisphosphonate Medication	☐YES ☐NO
Heart Murmur	☐YES ☐NO	Sexually transmitted diseases	☐YES ☐NO	Osteoporosis	☐YES ☐NO
Cardiac Pacer	☐YES ☐NO	AIDS or HIV Infection	☐YES ☐NO	Glaucoma	☐YES ☐NO
Anemia	☐YES ☐NO	Hepatitis	☐YES ☐NO	Joint Replacement/Implant	☐YES ☐NO
Congenital Heart Failure	☐YES ☐NO	Liver Disease Jaundice	☐YES ☐NO	Cortisone/Steroid Medicine	☐YES ☐NO
Stroke	☐YES ☐NO	Kidney Disease	☐YES ☐NO	Cancer	☐YES ☐NO
High Cholesterol	☐YES ☐NO	Ulcer/Stomach Troubles	☐YES ☐NO	Phobias/Nervous Anxious	☐YES ☐NO
Pacemaker	☐YES ☐NO	Asthma or hay fever	☐YES ☐NO	TMJ Disorder	☐YES ☐NO
Prolonged Bleeding	☐YES ☐NO	Infectious/Contagious Disease	☐YES ☐NO	Mental Disorder	☐YES ☐NO

DENTAL HEALTH

Reason for visit: _____ When was your last dental visit? _____
Prior dentist name: _____ What was your last treatment? _____
Have you ever had any serious medical problem associated with previous dental treatment? ☐ YES ☐ NO
If yes, explain:

How often do you brush your teeth? _____ times/day. ♦ Smoke Tobacco? ☐ Yes ☐ No _____ cigarettes/day
What texture tooth brush do you use? ☐ Soft ☐ Medium ☐ Hard
Do you floss daily? ☐ Yes ☐ No Do your gums bleed when flossing or brushing? ☐ Yes ☐ No
Do your gums feel tender or swollen? ☐ Yes ☐ No
Do you feel pain when your teeth come in contact with ☐ Hot ☐ Cold ☐ Sweets ♦ Gagging easily? ☐ Yes ☐ No
Do you chew on one side of your mouth? ☐ Yes ☐ No If yes, explain: _____

Do you clench or grind your jaws while sleeping or during the day? ☐ Yes ☐ No
Do your jaws ever feel tired? ☐ Yes ☐ No ♦ Do your jaws "pop" or "click?" ☐ Yes ☐ No ♦ Facial Pain? ☐ Yes ☐ No
Numbness in lower lip or jawbone ☐ Yes ☐ No
Would you like to change anything about your smile? ☐ Yes ☐ No
If yes, explain: _____
Do you feel your oral condition is affecting your general health in any way? _____

Please add anything you feel is important: _____

INSURANCE INFORMATION

Name of Insured: _____ DOB _____ SSN: _____ Relationship to patient _____
Employer: _____ Address: _____
Insurance Company: _____ GROUP# _____ Policy# _____
Additional Insurance: ☐ Yes ☐ No
Name of Insured: _____ DOB _____ SSN: _____ Relationship to patient _____
Employer: _____ Address: _____
Insurance Company: _____ GROUP# _____ Policy# _____
If patient is a student, Name of School/College: _____

HOW DID YOU FIRST HEAR ABOUT US? (Click any that apply)

☐ Family / Friend Referral, **Who?** _____
☐ Convenient location (Walking by) _____
☐ I got a Flyer / Postcard in Mail _____
☐ Internet: ___Google search Other? _____
☐ Social Media: ___Facebook ___Twitter ___LinkedIn ___Instagram
☐ I saw your Website online/ Business Directories _____
☐ Magazine Ads in mail or stand _____
☐ YELP _____
☐ Others (Specifically)? _____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1- I am changing dentists because: (Check any that apply)

- ☐ Recently moved into this area from: _____
- ☐ Dr / Staff Personality – Communication Problem
- ☐ Inadequate Care – Fee Concern - Insurance
- ☐ I need a second opinion or better option on dental care
- ☐ To find a dentist team who understands my needs

2- I have avoided dental care in the past because:

- ☐ Time commitment
- ☐ Financial commitment
- ☐ No perceived need
- ☐ Trust factor
- ☐ Fear of_____

I, the undersigned, hereby authorize the release of any information including the diagnosis and the records of any treatments or examinations rendered, to my insurance company or companies. This release is solely for the purpose of facilitating the billing and reimbursements, directly to the Dental Provider, of insurance benefits under which I am entitled. I understand that I am responsible for all charges for treatment to me regardless of insurance coverage.

_____ (DATE)

_____ (SIGNATURE)

INFORMED CONSENT

1. I am responsible for *ALL* charges related to services provided to me at the usual and customary charges of the dental office.
2. I hereby grant authority to the dentist(s) in charge of my care to administer treatment, 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, benefits, alternatives and possible consequences of the treatment proposed and I authorize the treatment.
3. Dental treatment may include examination, x-rays, cleaning, gum disease treatment, fillings, root canals, extractions and prosthodontics usually with local anesthesia. If the cavity in the tooth is very deep, the removal of the nerve or the tooth may be necessary. We would like to provide you with complete information regarding the risks and benefits of your dental treatment.
4. I was provided with the DENTAL MATERIALS FACE SHEET as required by a California Law. I also under stand that The Fact Sheet would be provided to me anytime in the future upon my request

SIGNED **X** _____ DATE _____

Thank You