Patient Health Record

(Please Print)

NAME (Last) (first)

DATE _____

NAME (First) (Middle) (Last)

HOME ADDRESS CITY, STATE ZIP CODE PHONE

EMPLOYED BY BUSINESS ADDRESS BUSINESS PHONE

OCCUPATION DATE OF BIRTH SEX SOCIAL SECURITY NO.

TYPE OF DENTAL INSURANCE (If applicable) REFERRED BY: YELLOW PAGES ☐

SPOUSE'S NAME (IF A CHILD, PARENT'S NAME) DATE OF BIRTH SOCIAL SECURITY NO.

DENTAL HEALTH

Reason for visit _____ Last dental visit _____

Have you ever had any serious problem associated with pervious dental treatment? ..... Yes ☐ No ☐

If yes, please explain _____

Former or current dentist's name and address _____

MEDICAL HEALTH

Name and address of physician _____

Do you have any medical problems? _____

Are you taking any medication(s) or drug(s) now? .....Yes ☐ No ☐ Have you taking Phen-Fen? .....Yes ☐ No ☐

Please list any medications, recreational drugs or vitamins you are or have recently taken _____

_____

For what purpose? _____

Have you ever been treated for:

Heart disease ..... Yes ☐ No ☐
Rheumatic fever ..... Yes ☐ No ☐
Abnormal blood Pressure .....Yes ☐ No ☐
Ulcers or G.I. problems .....Yes ☐ No ☐
Tuberculosis or lung disease ..... Yes ☐ No ☐
Diabetes .....Yes ☐ No ☐

Epilepsy..... Yes ☐ No ☐
Congenital heart lesions ..... Yes ☐ No ☐
Heart murmur ..... Yes ☐ No ☐
Sinus trouble ..... Yes ☐ No ☐
Hepatitis or liver disease ..... Yes ☐ No ☐
Stroke ..... Yes ☐ No ☐

☐ Other illnesses _____

Are you allergic to: Penicillin ☐ ; Codeine ☐ ; Local injected anesthetics ☐ ; Latex ☐: Other medications ☐ _____

Other medications ☐ _____ ; No known allergies ☐ _____ Initials

Are you subject to prolonged bleeding? ..... Yes ☐ No ☐
Are you subject to fainting spells? ..... Yes ☐ No ☐
Are you a smoker or tobacco user? ..... Yes ☐ No ☐
Are you pregnant? Yes ☐ No ☐ How long? _____

Fees are paid at the time services are rendered unless prior arrangements have been made. Any unpaid balance shall be subject to interest at an annual rate of 21%. If my balance becomes delinquent I hereby agree to pay all attorney and collection fees. At my request a Federal Truth in Lending Statement can be provided to me. All returned checks are subject to a $20 fee and will be treated under the Arizona check collection laws. A fee of $25 per 1/2 hour appointment may be charged for appointments canceled without at least a 24-hour notice.

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PATIENT SIGNATURES (or guardian)