PATIENT HEALTH RECORD

DATE_____

PATIENT"S NAME_____AGE_____DATE OF BIRTH_____

ADDRESS_____HOME TELEPHONE #_____

CELL PHONE #_____

TOWN_____ZIP_____SS#_____

PATIENT PLACE OF EMPLOYMENT_____BUS. TEL.: _____

GUARDIAN OR SPOUSE_____PLACE OF EMPLOYMENT_____

BUSINESS TELEPHONE #_____

REFERRED BY_____ADDRESS (STREET)_____

(TOWN)_____

PERSON RESPONSIBLE FOR ACCOUNT_____

ADDRESS_____RELATIONSHIP_____SS#_____

COMPLETE IF YOU ARE COVERED UNDER DENTAL INSURANCE

HAS ANY OF YOUR INSURANCE INFORMATION CHANGED? ☐ YES ☐ NO (IF NO, PLEASE SKIP)

MEMBERSHIP #_____

PRIMARY INSURANCE CARRIER_____EMPLOYEE NAME_____

EMPLOYEE SOCIAL SECURITY #_____EMPLOYER_____

RELATIONSHIP OF THE PATIENT TO THE INSURED_____

SECONDARY INSURANCE CARRIER_____EMPLOYEE NAME_____MEMBERSHIP #_____

SOCIAL SECURITY #_____EMPLOYER_____

MEDICAL HEALTH

PERSONAL PHYSICIAN_____ADDRESS_____

LAST PHYSICAL_____ _____

DO YOU CURRENTLY HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS?

*WHEN DIAGNOSED (W/D)

Rheumatic Fever ..... Yes ☐ No ☐ W/D_____
Scarlet Fever ..... Yes ☐ No ☐ W/D_____
Hepatitis ..... Yes ☐ No ☐ W/D_____
(Which type? _____)
Tuberculosis ..... Yes ☐ No ☐ W/D_____
Lung Disease ..... Yes ☐ No ☐ W/D_____
Sexually Transmitted Diseases ..... Yes ☐ No ☐ W/D_____
Herpes ..... Yes ☐ No ☐ W/D_____
HIV/Aids ..... Yes ☐ No ☐ W/D_____
Mitral Valve Prolapse ... Yes ☐ No ☐ W/D_____
Heart Murmur ..... Yes ☐ No ☐ W/D_____
Congenital Heart Lesions Yes ☐ No ☐ W/D_____
Subacute Bacterial Endocarditis ..... Yes ☐ No ☐ W/D_____
Heart Disease ..... Yes ☐ No ☐ W/D_____
History of Heart Attack .. Yes ☐ No ☐ W/D_____
Bypass surgery ..... Yes ☐ No ☐ W/D_____
(Date _____)

Angina Pectoris ..... Yes ☐ No ☐
Abnormal Blood Pressure ..... Yes ☐ No ☐
Stroke ..... Yes ☐ No ☐
Asthma ..... Yes ☐ No ☐
Sinus Trouble ..... Yes ☐ No ☐
Hay Fever ..... Yes ☐ No ☐
Cough ..... Yes ☐ No ☐
Epilepsy ..... Yes ☐ No ☐
Hemophilia ..... Yes ☐ No ☐
Anemia ..... Yes ☐ No ☐
Cancer Site..... Yes ☐ No ☐
Diabetes ..... Yes ☐ No ☐
Jaundice ..... Yes ☐ No ☐
Liver Disease ..... Yes ☐ No ☐
Arthritis or Rheumatism .. Yes ☐ No ☐
Headaches ..... Yes ☐ No ☐
Chemical Dependency ... Yes ☐ No ☐
Back Problems ..... Yes ☐ No ☐

Immunosuppressive Disorder ..... Yes ☐ No ☐
Artificial Heart Valves or Joints ..... Yes ☐ No ☐
Hip Replacements, Pins, Rods or Implants ..... Yes ☐ No ☐
Where_____

Digestive Disorders ..... Yes ☐ No ☐
Ulcers ..... Yes ☐ No ☐
Glaucoma ..... Yes ☐ No ☐
Other ..... Yes ☐ No ☐
Explain _____

(over)

Do you have any allergies? ☐ Yes ☐ No

If yes, explain_____

Are you allergic or have you had an adverse reaction to any of the following?
☐ Penicillin
☐ Erythromycin
☐ Tetracycline
☐ Codeine
☐ Aspirin
☐ Ibuprofen
☐ Other Medications

Please list any medications that you are currently taking and list reason:_____

_____

Are you allergic to latex? ..... Yes ☐ No ☐
Are you allergic to local anesthetics? ..... Yes ☐ No ☐
Do you use tobacco? ..... Yes ☐ No ☐
Please specify: ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Chewing Tobacco
Please specify frequency:_____
Are you subject to fainting spells? ..... Yes ☐ No ☐
Are you subject to prolonged bleeding? ..... Yes ☐ No ☐
Are you pregnant? ..... Yes ☐ No ☐
Due Date:_____
Have you been hospitalized within the last five years? ..... Yes ☐ No ☐
If yes, please explain:_____

DENTAL HEALTH

Reason for visit:_____

When was your last dental visit?_____

Have you ever had any serious problem associated with dental treatment? ..... Yes ☐ No ☐
If so, explain:_____

Which texture brush do you use? ☐ SOFT ☐ MEDIUM ☐ HARD

How often do you brush?_____ How often do you floss?_____

Do your gums bleed while brushing or flossing? ..... Yes ☐ No ☐
Do your gums feel tender or swollen? ..... Yes ☐ No ☐
Do you suffer from dry mouth? ..... Yes ☐ No ☐
Do you avoid brushing any part of your mouth because of pain? ..... Yes ☐ No ☐
Do you experience sensitivity to hot, cold, or sweets? ..... Yes ☐ No ☐
If so, please specify and explain:_____
Do you chew on only one side of your mouth? ..... Yes ☐ No ☐
If so, please explain:_____
Do you clench or grind your jaws while sleeping or during the day? ..... Yes ☐ No ☐
Do you currently wear a night guard? ..... Yes ☐ No ☐

Is there anything about the way your teeth look that you would change if you could?_____

_____

_____

List herbal supplements and/or medicine prescribed by naturopathic doctor. _____

_____

_____

_____

PATIENT'S SIGNATURE_____