GLOWING SMILE DENTAL STUDIO

Please fill out this Patient Health Record as complete as possible.

1 PATIENT INFORMATION

Today's Date: _____

Patient Name: _____
Last Name

_____
First Name Middle Initial

Birthdate: _____ Sex: ☐ M ☐ F

Social Security #: _____

Driver's License #: _____

☐ Married ☐ Widowed ☐ Single
☐ Minor ☐ Separated ☐ Divorced

E-Mail: _____

Address: _____

_____

City: _____

Sate: _____ Zip _____

Patient Employer: _____

Employer Phone #: _____

Whom may we thank for referring you?

_____

2 PHONE NUMBERS

Patient Home / Cell #: _____

Patient Work #: _____ Ext: _____

Best time and place to reach you:

_____

IN CASE OF EMERGENCY, CONTACT
(Specify someone who does **not** *live in your household.)*

Name: _____

Relationship: _____

Home / Cell #: _____

Work #: _____ Ext: _____

3 DENTAL BENEFITS

INSURANCE INFORMATION

Company: _____

Phone #: _____

Subscriber ID#: _____

Group #: _____

RESPONSIBLE PARTY

Who is responsible for any account balance?:

_____

Relationship to Patient: _____

Birthdate: _____ Sex: ☐ M ☐ F

Social Security #: _____

Driver's License #: _____

Employer: _____

Home / Cell #: _____

Work #: _____ Ext: _____

4 ALLERGIES

Aspirin	☐ Yes ☐ No
Barbiturates (Sleeping Pills)	☐ Yes ☐ No
Codeine	☐ Yes ☐ No
Iodine	☐ Yes ☐ No
Latex	☐ Yes ☐ No
Iodine	☐ Yes ☐ No
Other	☐ Yes ☐ No

5 MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____

_____

_____

Pharmacy Name: _____

Phone: _____

6 DENTAL INFORMATION

Reason for today's visit: _____

_____

Former Dentist: _____

Phone#: _____ Fax#:

_____

City/State: _____

Date of last dental visit: _____

Date of last dental X-Rays: _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad Breath	☐ Yes	☐ No	Fingernail biting	☐ Yes	☐ No
Bleeding Gums	☐ Yes	☐ No	Food collection between teeth	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No	Grinding teeth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No	Gums swollen or tender	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No	Jaw pain or tiredness	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No	Lip or cheek biting	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No	Loose teeth or broken fillings	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No	Mouth breathing	☐ Yes	☐ No
			Mouth pain, brushing	☐ Yes	☐ No
			Orthodontic treatment	☐ Yes	☐ No
			Pain around ear	☐ Yes	☐ No
			Periodontal treatment	☐ Yes	☐ No
			Sensitivity to cold	☐ Yes	☐ No
			Sensitivity to heat	☐ Yes	☐ No
			Sensitivity to sweets	☐ Yes	☐ No
			Sensitivity when biting	☐ Yes	☐ No
			Sores or growths in your mouth	☐ Yes	☐ No

How often do you floss? _____

How often do you brush? _____

7 MEDICAL HEALTH

Physician's Name: _____ Date of last visit: _____

Phone#: _____ Fax#: _____ City/State: _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Lonimin, Adipex, Fastin (Brand names of Phentermine). Pondimin (Fenfluramine) and Redux (Dexfenfluramine). ☐ Yes ☐ No

Women

Are you pregnant? ☐ Yes ☐ No Due Date: _____

Are you nursing? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Chemotherapy	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Circulatory Problems	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Congenital Heart Lesions	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Cortisone Treatments	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Cough, persistent or bloody	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Bleeding abnormally,			Emphysema	☐ Yes	☐ No
(with extractions or surgery)	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Fainting or dizziness	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No

Headaches	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Heart Murmur	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Heart Problems	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Hepatitis Type	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Herpes	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No
Jaundice	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Jaw Pain	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No
Kidney Disease	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Liver Disease	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Low Blood Pressure	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Mitral Valve Prolapse	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Nervous System Problems	☐ Yes ☐ No	Tumor/growth on head or neck	☐ Yes ☐ No
Pacemaker	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Psychiatric Care	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Radiation Treatment	☐ Yes ☐ No	Weight Loss, (unexplained)	☐ Yes ☐ No
Respiratory Disease	☐ Yes ☐ No	Do you wear contact lenses?	☐ Yes ☐ No

On a scale of 1-10 (10 being the most) how happy are you with your smile?

1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

I wish my teeth were:

___Whiter ___Straighter ___Healthier ___ I am happy with my smile

_____ _____

Signature of Patient, Parent, Guardian/Personal Representative Date

_____

Please Print Name of Patient, Parent, Guardian/Personal Representative

Doctor's Signature: _____ Date: _____