Patient Health Record **Date ____/____/____**

Mr./Mrs./Ms./Miss _____Last, First, Middle

Home Address _____(city) (zip)

Home Telephone _____ Work Telephone _____

E-Mail Address _____

Date of Birth ___/___/___ Marital status (circle) S M D W Sex: M F

Do you have Dental Insurance? Y / N
If so, what type? _____ Social Security # ___/___/_____

Whom may we thank for referring you to our office? _____

Name and Address of Physician: _____

Date of your last complete physical: _____

Do you smoke? (circle) Y / N If yes, how long have you smoked? _____

Are you taking any medication at the present time? Y / N If yes, for what purpose?
_____Are you allergic to: Penicillin: Y / N Local Anesthetics? Y / N

Please circle if applicable.	Have you had/have or been treated for:	
High Blood Pressure	Anemia	Rheumatic Fever
Low Blood Pressure	Asthma	Jaundice
Heart Attack/Stroke	Chemotherapy	Gastrointestinal Problem
Pacemaker	Diabetes	Glaucoma
Neurological Problem	HIV	Venereal Disease
Heart Murmur	Cancer	Thyroid Problem
Lung Problem	Tuberculosis	Liver problem
Hepatitis	Epilepsy	Artificial Joints

(Women) Are you Pregnant? Y / N If yes, expected due date _____

Have you had any surgery of any kind? Y / N Do you heal properly? Y / N

Please add anything you may feel is important for us to know.

Office policy: Payment is due at time services are rendered unless prior arrangements are made. To avoid charges for broken appointments, 24-hour prior notice is required.

Signature of patient or responsible party_____Date:_____