

Patient Record

Patient Name: _____ Referred By: _____

Home Address: _____ City: _____ Zip: _____ E-mail _____

Home Phone: () _____ Cell Phone: () _____ Receive Text: Yes or No Preferred Contact Method: _____

Social Security Number: ____ - ____ - _____ Date of Birth: _____

Sex: _____ Age: _____ Height: _____ Weight: _____ Marital Status: M S D W

Employer: _____ Occupation: _____

Business Address: _____ Business Phone: () _____

Spouse's Name: _____ Social Security Number: ____ - ____ - _____ Date of Birth: _____

Employer: _____ Occupation: _____

Business Address: _____ Business Phone: () _____

Name of Person Responsible For Expenses Incurred: _____

Name of Insurance Company: _____ Group Number: _____

Address: _____

Enrollee/Member's Name: _____ Member's Social Security Number: ____ - ____ - _____

Medical Doctor's Name: _____ Phone: () _____

Last Complete Physical Exam: _____ Are You Taking Any Medications Now? Yes No

Name of Medication and Purpose: _____

Heart Disease	Y	N	High Blood Pressure	Y	N	Glaucoma	Y	N
Prosthetic Valves/Joints	Y	N	Low Blood Pressure	Y	N	Radiation Therapy	Y	N
Ulcers	Y	N	HIV + AIDS	Y	N	Dry Mouth	Y	N
Tuberculosis/Lung Disease	Y	N	Heart murmur	Y	N	Epilepsy	Y	N
Diabetes	Y	N	Mitral Valve Prolapse	Y	N	Arthritis	Y	N
Anemia	Y	N	Hepatitis A	B	C	Allergies: Circle any that apply		
Congenital Heart Lesions	Y	N	Asthma	Y	N	Aspirin	Codeine	Dental Anesthetics
Rheumatic Fever	Y	N	Pregnancy	Y	N	Penicillin	Tetracycline	Erythromycin
Stroke	Y	N	Prolonged Bleeding	Y	N	Latex	Other: _____	

Primary Reason for Consultation: _____

Date of Last Dental Exam: _____ Date of Last Dental X-rays: _____

I hereby certify that I have read and understand the foregoing disclosure statement.

Insured or Authorized Person _____ Date _____