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: ____

PLEASE CIRCLE ONE

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	Hepatitis	A	B C
Anemia	Y	N	Arthritis	Y	N	**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 __________________