PATIENT HEALTH RECORD

DATE _____ Cell _____

PHONE NUMBER _____

NAME ^ (Last) (First) (Middle) SOCIAL SECURITY #

ADDRESS

EMPLOYER ADDRESS OF EMPLOYER EMPLOYER'S PHONE NUMBER

DATE OF BIRTH SEX WEIGHT HEIGHT OCCUPATION

Single Married Widowed Divorced

MARITAL STATUS (circle one) SPOUSE'S NAME SPOUSE'S DATE OF BIRTH SPOUSE'S SOCIAL SECURITY #

DENTAL INSURANCE INFORMATION (who carries the insurance, employer if different than above, insurance company name, address & phone #)

DATE OF LAST MEDICAL PHYSICAL EXAM PHYSICIAN NAME PHYSICIAN PHONE #

PHARMACY NAME CITY PHARMACY PHONE # REFERRED BY

Do you smoke or use tobacco? YES NO What is your impression of your present health_____

If Female Please Answer the Following: Are you taking Birth Control Pills? YES NO Are you pregnant? YES NO If yes # of weeks_____ Are you nursing YES

DO YOU HAVE A HISTORY OF THE FOLLOWING: (Please circle Y for Yes or N for No for each item)

Y N	ALCOHOL/DRUG ABUSE	Y N	FAINTING SPELLS	Y N	HEPATITIS	Y N	RHEUMATIC FEVER
Y N	ARTHRITIS	Y N	FEVER BLISTERS	Y N	HIGH BLOOD PRESSURE	Y N	SHORTNESS OF BREATH
Y N	ARTIFICIAL JOINTS	Y N	FREQUENT HEADACHES	Y N	HIV+ AIDS	Y N	SINUS PROBLEMS
Y N	ASTHMA	Y N	FREQUENT CHEST PAIN	Y N	HIVES, SKIN RASHES	Y N	SWELLING OF ANKLES
Y N	CANCER	Y N	GLAUCOMA	Y N	KIDNEY DISEASE	Y N	TB (tuberculosis)
Y N	CONVULSIONS	Y N	HEART CONDITION	Y N	LIVER DISEASE	Y N	THYROID DISEASE
Y N	DIABETES	Y N	HEART SURGERY	Y N	LUNG DISEASE	Y N	ULCERS
Y N	RADIATION THERAPY						

Check Yes or No. If "Yes" explain	YES	NO
ARE YOU PRESENTLY, OR HAVE YOU BEEN UNDER THE CARE OF A PHYSICIAN DURING THE PAST YEAR?		
ARE YOU PRESENTLY TAKING ANY MEDICINE OR DRUGS? (If yes please list)		
ARE YOU ALLERGIC TO ANY MEDICINE OR MATERIALS? (If yes please list)		
HAVE YOU EVER HAD A REACTION TO A LOCAL ANESTHETIC OR EXPERIENCED ANY COMPLICATIONS OR ILLNESS FOLLOWING DENTAL TREATMENT?		
HAVE YOU EVER HAD INSTANCES OF PROLONGED OR UNUSUAL BLEEDING? DO YOU BRUISE EASILY?		
HAVE YOU BEEN SATISFIED WITH PREVIOUS DENTAL TREATMENT? (If no please explain)		
DO YOU HAVE ANY OTHER DISEASES, CONDITIONS OR PROBLEMS NOT LISTED ABOVE THAT YOUR DENTIST SHOULD KNOW ABOUT BEFORE PROCEEDING WITH THE TREATMENT? PLEASE EXPLAIN.		

THE UNDERSIGNED CONSENTS TO NECESSARY RADIOGRAPHIC SURVEYS, ANESTHESIA, DIAGNOSIS, AND DENTAL TREATMENT. THE UNDERSIGNED MAY ELECT NOT TO UNDERGO CERTAIN SPECIFIC PROCEDURES.

MY SIGNATURE IS CONSENT FOR COLFAX DENTAL SERVICES TO SUBMIT CHARGES TO MY INSURANCE COMPANY, AND IT SERVES AS SIGNATURE ON FILE IN LIEU OF AN INSURANCE FORM.

SIGNATURE OF PATIENT Email _____ DATE