Patient Health Record Update

Personal Information

Legal Name: Ms. Mrs. Mr. Dr. ________________________________ Name you prefer to be called: ____________
SSN: __ __ __ - __ __ - __ __ __ __ Date of Birth: __ __ / __ __ / __ __ __ __ Sex: ___ M ___ F
Are You a Full-Time Student?____ If So, Which School? ________________ Employer: ______________________
Marital Status: ___ S ___ M ___ D ___ W Spouse Name: ___________________ Spouse Employer: __________

Contact Information

Address: ____
____
City: _________________ State: ____ Zip: ________
E-mail: ____

Phone Numbers: Home: (___) ____ - _____
Cell: (___) ____ - _____
Work: (___) ____ - _____
Spouse: (___) ____ - _____

Dental History

What is the primary reason for your appointment today?
____
When was your last dental appointment?
____
What treatment did you have?
____
When were your last x-rays? ___________What type? _____Bitewings _____ Panorex _____Full Mouth Series

May we request your dental records and x-rays from your previous dentist if needed? __ Yes __ No

If so, Name of the dentist: _________________________________ Phone number: _________________

Health Information

Are you currently under a physician's care? ___ Yes ___ No
If yes, what is the name and phone number of your doctor? Name: ______________________ (___) ____ - _____
Are you pregnant? ___ Yes ___ No ___ N/A
If yes, what is the name and phone number of your doctor? Name: ______________________ (___) ____ - _____
Have you been hospitalized in the past 5 years? ___ Yes ___ No
If yes, what for? ____

Do you have any allergies or are you sensitive to drugs such as penicillin, aspirin, codeine, local anesthetics, etc.?
What are you allergic to and what type of reactions do you have? _____ No _____ Yes
Reaction: ____

What is the phone number of your preferred pharmacy? Name: __________________ (___) ____ - _____

Do you have fluoride in your water source at home? ___ Yes ___ No
If you have any other source of water other than city/county water, please list: ______________________

Do you need to be premedicated for your heart or recent joint replacement? _____ Yes _____ No
If yes, What are you traditionally premedicated with? ☐Amoxicillin ☐Clindamycin ☐ Cephalexin ☐Other:

Medical Information

Please list prescription or over-the-counter medications (including vitamins or herbs) that you are currently taking:

Medication, Herb or Vitamin Name	Dosage	For What Purpose Are You Taking It?

Who may we thank for sending you to our office? ______________________________
(or how did you find out about us?)

Emergency Contact

Who may we contact in the case of an emergency?

Name: ____ Phone Number: (____) ____ - _____

Do any of the Following Apply to You? (If not, please be sure to check "No".)

	YES	NO		YES	NO
Anemia	_____	_____	Heart Murmur	_____	_____
HIV / AIDS	_____	_____	Heart Problems	_____	_____
High Blood Pressure	_____	_____	Rheumatic Fever	_____	_____
Artificial Joints	_____	_____	Kidney Disease	_____	_____
Asthma	_____	_____	Liver Disease	_____	_____
Arthritis	_____	_____	Mental Health Concerns	_____	_____
Blood Disorders / Excessive Bleeding	_____	_____	Sinus Problems	_____	_____
Chemotherapy (Cancer)	_____	_____	Stroke	_____	_____
Cold Sores and/or Mouth Sores	_____	_____	Hepatitis: A ___ B ___ C ___	_____	_____
COPD	_____	_____	Sleep Apnea	_____	_____
Emphysema	_____	_____	Tuberculosis (TB)	_____	_____
Epilepsy or Seizures	_____	_____	Thyroid Problems	_____	_____
Fainting	_____	_____	Hypo ___ Hyper ___		
Diabetes: Type I ___ Type II ___	_____	_____	Dental Anxiety / Nervous	_____	_____
Jaw Discomfort (TMD)	_____	_____	Does your anxiety require		
Frequent Migraines or Headaches	_____	_____	premedication?	_____	_____
Taking Coumadin	_____	_____	Smoker	_____	_____
Taking Bisphosphonates	_____	_____	How Many Years? _____		
Recreational Drug Use	_____	_____	Alcohol Use	_____	_____
What Kind and When Last Taken?	_______________		Strong Gag Reflex	_____	_____

Please write below any further detail of all "Yes" answers on the above medical information section. Also include any additional health information you feel may be important:

____

____

Marketing Consent

I give permission to Dr. Sharon Harris and her staff to use the following items for publications and advertisements: (please check those items that you allow): ___ your name ___ teeth photos ___ face photos ___ stone models

Name: (patient, parent, guardian) ________________________Signature: ___________________________ Date: __________

Parental Consent

I allow my child to receive treatment from the doctor and staff. I allow my child to have the appropriate x-rays taken and fluoride treatment given.

Signature: ______________________________ Date: __ __ / __ __ / __ __ __ __

Printed Name: ___________________________ Relationship to patient: __________________________

Patient Consent

I understand there are no guarantees or warranties in health or dental care.

"Initial payments" are requested and appreciated at the time services are rendered. We accept Care Credit, cash, check and most major credit cards.

Dental benefit plans are accepted, however the patient is responsible for any balance not paid by the insurance company. *Please remember that these benefit plans are designed to assist in the cost of dental care, but not to completely cover the fees.* We have no direct connection to the insurance company so all quotes given are estimates only.

I plan to pay for any uncovered portion of my care with: ☐ Credit Card on File: Type of CC: ________ Card #:_____________________
☐ Bill Me by Mail

Delinquent accounts of 30 days or more carry a 1.5% monthly service charge, with a minimum fee of $2.00 per month. I understand that I am responsible for any collections, court costs, attorney fees, and cancellation fees that this account may incur.

Signature: ______________________________ Date: __ __ / __ __ / __ __ __ __

Printed Name: ___________________________ Relationship to patient: __________________________