O'Rourke Family and Cosmetic Dentistry - Patient Health Record

Whom may we thank for referring you to us? ____

Date: __/__/____ Age: ___ Date of Birth: __/__/____ SS#: ____-___-_____

Name: (Mr. Mrs. Miss Dr.)____
(Circle One) Last First Middle

Home Phone: __________________ Cell Phone: ___________________ Work Phone: ___________________

Spouse Name: _________________ Cell Phone: ___________________ Work Phone: ___________________

Home Address: _______________________________________ City: ___________________ Zip: ___________

Email Address: ______________________________________

Employer: ________________________________ Address: ____

Insurance Co: _____________________________ Policy #: _____________________ Gp#: _______________

Insured's ID #: ____________________________ Date of Birth: _________________

Address for Insurance Submission: ____

Spouse Employer: __________________________________ Ins. Co: __________________________________

Medical Health

Name/Address of Physician: ____

Have you been under a physician's care in past two years? ☐ Yes ☐ No For: __________________________

Have you been treated in a hospital in past two years? ☐ Yes ☐ No For: __________________________

Any major surgeries? ☐ Yes ☐ No If yes, describe: ____

Knee or Hip Replacement? ☐ Yes ☐ No If yes, date? ___________

Need for premedication/antibiotic prior to dental work? ☐ Yes ☐ No

Are you pregnant, nursing or menopausal? ☐ Yes ☐ No

On hormone replacement or birth control pills? ☐ Yes ☐ No

Allergic to: ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Latex Other: ______________________________

Please list ALL medications and supplements: ____

Have you had, or do you now have: (*if yes, list date and diagnosis)

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Epilepsy	☐	☐	Radiation Therapy	☐	☐
AIDS/HIV Positive	☐	☐	Fainting	☐	☐	Rheumatic Fever	☐	☐
Allergies	☐	☐	Heart Disease/Heart Attack	☐	☐	Sickle Cell Anemia	☐	☐
Anemia	☐	☐	Heart Murmur/Mitral Valve Prolapse	☐	☐	Smoke/Dip/Chew Tobacco	☐	☐
Angina/Chest Pain	☐	☐	Hepatitis	☐	☐	Stroke	☐	☐
Arthritis	☐	☐	Herpes/Fever Blisters Lips	☐	☐	Thyroid Disease	☐	☐
Artificial Heart Valves	☐	☐	Kidney Disease	☐	☐	Tuberculosis	☐	☐
Artificial Joints	☐	☐	Liver Disease/Jaundice	☐	☐	Ulcers Stomach/Mouth	☐	☐
Asthma	☐	☐	Organ Transplant	☐	☐	Venereal Disease	☐	☐
Cancer	☐	☐	Osteoporosis	☐	☐	Date/Diagnosis info:		
Chemotherapy	☐	☐	Pacemaker	☐	☐			
Congenital Heart Lesions	☐	☐	Prolonged Bleeding	☐	☐			
Diabetes	☐	☐	Prolonged Cough	☐	☐			
Drug Dependency	☐	☐	Psychiatric Treatment	☐	☐			

Have you any disease, conditions, or problems not previously listed? ____

I, _________________________________, consent to a dental exam including x-rays for diagnosis of current dental condition.

____ _____________________________

Signature Date