O'Rourke Family and Cosmetic Dentistry

Patient Health Record/Update

Name _____ Date _____
Age _____ Date of Birth _____ SS# _____
Home Address _____ City/Zip _____
Home Phone _____ Mobile Phone _____ Work Phone _____
May we leave a voice message? Yes ☐ No ☐
Emergency Contact Name _____ Phone Number _____
Insurance Co _____ Name of Insured _____
ID# _____ Gp# _____ DOB of Insured _____
How did you find us? Billboard ☐ Website ☐ Church Bulletin ☐ Pinecrest Academy ☐ Patient ☐ Other ☐ _____
Date of Last Physical Exam _____ Name of Physician _____
Pharmacy Name/Number _____
Have you been hospitalized or under a Physician's Care in the past 2 years? Yes ☐ No ☐ If yes, for _____
Any major surgeries? Yes ☐ No ☐ If yes, please describe. _____
Knee or Hip Replacement? Yes ☐ No ☐ Date _____ Do you take antibiotics prior to dental work? Yes ☐ No ☐
Pregnant or Nursing? Yes ☐ No ☐ Do you take birth control pills? Yes ☐ No ☐
Do you take osteoporosis meds, Fosamax, Boniva or other bisphosphonates? Yes ☐ No ☐
Allergic to: Latex ☐ Local Anesthetics ☐ Penicillin ☐ Aspirin ☐ NSAIDS ☐ Codeine ☐ Foods ☐
Please list **ALL** medications ***and*** supplements:
_____

Have you had, or do you now have:

High Cholesterol	☐	Emphysema/COPD	☐	Respiratory Issues	☐
High blood Pressure	☐	Epilepsy/Seizures	☐	Rheumatic Fever	☐
Atrial Fibrillation	☐	Fainting	☐	STD	☐
ADD/ADHD	☐	Gastric Reflux	☐	Severe Gag Reflex	☐
AIDS/HIV Positive	☐	Heart Attack / Date_____	☐	Sickle Cell Anemia	☐
Allergies	☐	Hepatitis	☐	Sleep Apnea	☐
Anemia	☐	Herpes/Fever Blisters	☐	Smoke/Dip	☐
Angina/Chest Pain	☐	Kidney Disease	☐	Stroke / Date _____	☐
Artificial Heart Valves	☐	Liver Disease	☐	Thyroid Disease	☐
Artificial Joints	☐	Organ Transplant	☐	Tuberculosis	☐
Asthma	☐	Osteoporosis	☐	Stomach Ulcers	☐
Cancer / Type_____	☐	Pacemaker	☐	Anything Not Listed _____	
Chemotherapy	☐	Prolonged Bleeding	☐	_____	
Compromised Immunity	☐	Pneumonia	☐	☐ I understand that withholding	
Congenital Heart Defect	☐	Prolonged Cough	☐	information could seriously	
Diabetes	☐	Psychiatric Care	☐	jeopardize my safety and I have	
Diarrhea	☐	Recreational Drug Use	☐	answered truthfully to the best of	
Drug Dependency	☐	Radiation Therapy	☐	my knowledge.	

☐ I consent to a dental exam including x-rays, photographs, study models or other diagnostic aids deemed appropriate by the doctor to make a complete diagnosis of my current dental condition.

_____ _____
Signature Date