O'Rourke Family and Cosmetic Dentistry - Patient Health Record

How did you find us? ☐ Billboard ☐ Website ☐ Church Bulletin ☐ Pinecrest Academy ☐ Direct Mail
Whom may we thank for referring you to us? _____ ☐ Patient ☐ Other

Date: _____ Age: ____ Date of Birth: _____ SS#: ____-___-_____
Name: (Mr. Mrs. Miss Dr.)_____
(Circle One) Last First Middle
Home Address: _____ City: _____ Zip: _____
Email Address: _____
Home Phone: _____ **Cell Phone**: _____ Work Phone: _____
Spouse Name: _____ Cell Phone: _____ Work Phone: _____
Minor Children's Names/Ages_____**Will they be patients**?_____
Employer: _____ Occupation: _____ Spouse Occupation: _____
Insurance Co: _____ Policy #: _____ Gp#: _____
Insured's ID #: _____ Insured Date of Birth: _____
Address for Insurance Submission: _____
Spouse Employer: _____Spouse Ins. Co: _____

Medical Health
Date of Last Physical Exam: _____ Name/Phone Number of Physician: _____
Have you been hospitalized or under a physician's care in past 2 years? ☐ Yes ☐ No For: _____
Any major surgeries? ☐ Yes ☐ No If yes, describe: _____
Knee or Hip Replacement? ☐ Yes ☐ No Date: _____ Do you take antibiotics prior to dental work? ☐ Yes ☐ No
Are you 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: (**if yes, list date and diagnosis*)

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Emphysema/COPD	☐	☐	Radiation Therapy	☐	☐
Atrial Fibrillation	☐	☐	Epilepsy/Seizures	☐	☐	Respiratory problems	☐	☐
ADD/ADHD	☐	☐	Fainting	☐	☐	Rheumatic Fever	☐	☐
AIDS/HIV Positive	☐	☐	Gastric Reflux	☐	☐	STD	☐	☐
Allergies	☐	☐	Heart Attack	☐	☐	Severe Gag Reflex	☐	☐
Anemia	☐	☐	Hepatitis	☐	☐	Sickle Cell Anemia	☐	☐
Angina/Chest Pain	☐	☐	Herpes/Fever Blister	☐	☐	Sleep Apnea	☐	☐
Artificial Heart Valves	☐	☐	Kidney Disease	☐	☐	Smoke/Dip	☐	☐
Artificial Joints	☐	☐	Liver Disease	☐	☐	Stroke	☐	☐
Asthma	☐	☐	Organ Transplant	☐	☐	Thyroid Disease	☐	☐
Cancer	☐	☐	Osteoporosis	☐	☐	Tuberculosis	☐	☐
Chemotherapy	☐	☐	Pacemaker	☐	☐	Ulcers Stomach	☐	☐
Compromised Immunity	☐	☐	Prolonged Bleeding	☐	☐	Anything Not Listed: _____		
Congenital Heart Defect	☐	☐	Pneumonia	☐	☐	✓I understand that withholding any information		
Diabetes	☐	☐	Prolonged Cough	☐	☐	could seriously jeopardize my safety and I have		
Diarrhea	☐	☐	Psychiatric Care	☐	☐	answered truthfully to the best of my knowledge.		
Drug Dependency	☐	☐	Recreational Drug Use	☐	☐			

✓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

Rev. 9/15