ATLANTIC DENTAL WELLNESS: HOLISTIC, RESTORATIVE, & SPORTS DENTISTRY

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UPDATED PATIENT HEALTH RECORD

CONTACT INFORMATION

Patient Name: _____ Date: _____

Address: _____

Phone #: Home: _____ Work: _____ Cell: _____

E-mail address: _____

Employer/School: _____

Insurance Co.: _____

EMERGENCY CONTACT INFORMATION

Name_____

Relationship _____

Home Phone _____ Work Phone_____ Cell Phone _____

MEDICAL

Name and phone # of family doctor: _____

Have you been under a doctor's care during the past 2 years? Yes No For: _____

Have you been treated in a hospital in the past 2 years? Yes No For: _____

Have you ever had major surgery? Yes No For: _____

WOMEN

Are you pregnant? Yes No – If yes, what is your due date? _____

Are you currently breast feeding? Yes No

Are you taking oral contraceptives? Yes No

Please mark yes or no to indicate if you have had any of the following.

Chest Pain	Yes No	Shortness of Breath	Yes No	Hives or Skin Rash	Yes No
Heart Failure	Yes No	Ulcers	Yes No	Alcoholism	Yes No
Heart Disease or Attack	Yes No	Mental Illness	Yes No	Herpes	Yes No
When? _____					
Angina Pectoris	Yes No	Emphysema	Yes No	Glaucoma	Yes No
Heart Problems	Yes No	Fainting or dizzy spells	Yes No	*Steroid Treatment	Yes No
Liver Disease	Yes No	Eating disorder	Yes No	Arthritis	Yes No

Heart Surgery	Yes No	Epilepsy or Seizures	Yes No	*Any type of Implant	Yes No
				What Type? _____	
High Blood Pressure	Yes No	Persistent Cough	Yes No	Cancer	Yes No
				What Type? _____	
*Heart Murmur	Yes No	Tuberculosis	Yes No	Birth Defects	Yes No
*Rheumatic Fever	Yes No	Asthma	Yes No	HIV Positive, ARC, AIDS	Yes No
Psychiatric Treatment	Yes No	*Congenital Heart Prob.	Yes No	Hay Fever	Yes No
Sickle Cell Disease	Yes No	Hepatitis A(Infectious)	Yes No	Use of tobacco	Yes No
Sinus Trouble	Yes No	Hepatitis B(Serum)	Yes No	Bruise easily	Yes No
*Artificial Joints	Yes No	Hepatitis C or other	Yes No	Jaundice	Yes No
Thyroid Disease	Yes No	Heart Pacemaker	Yes No	Heart Surgery	Yes No
Anemia	Yes No	Stroke	Yes No	Kidney Trouble	Yes No
Blood Transfusion	Yes No	Drug Addiction	Yes No	Hemophilia	Yes No
*Any type of transplant	Yes No	Cold Sores	Yes No	Diabetes	Yes No
*Mitral Valve Prolapse	Yes No	Radiation Therapy	Yes No	Chemotherapy	Yes No

Antibiotic pre-medication may be required prior to your appointment.

Are you required to Pre-Medicate before dental treatment? Yes No

ALLERGIES

Are your ALLERGIC or have you ever experienced any reaction to the following?

Local Anesthetics(Novocain)	Yes No	Aspirin or codeine	Yes No
Barbiturates/sedatives/sleeping pills	Yes No	Sulfa drugs	Yes No
Penicillin/other antibiotics	Yes No	Others_____	

MEDICATIONS

Are you taking any of the following medications?

Antibiotics/sulfa drugs	Yes No	Tranquilizers	Yes No
Blood thinners	Yes No	Insulin/other diabetes drugs	Yes No
Blood pressure medications	Yes No	Digitalis/other heart drugs	Yes No
Thyroid medications	Yes No	Nitroglycerin	Yes No
Cortisone/steroids	Yes No	Aspirin	Yes No
Antihistamines/allergy drugs	Yes No		

Prescription medication(s): _____

_____

Patient Signature: _____ **Date:** _____

Doctors Signature: _____ **Date:** _____