

PATIENT HEALTH RECORD

Date _____

Dr. Mr. Mrs. Ms. _____ Nickname _____
(last) (first) (initial)

Address _____
(street) (city) (state) (zip)

Home Phone (____) _____ Cell (____) _____ Business (____) _____

Date of Birth _____ Social Security No. ____ - ____ - ____ Sex: M F

Height ____ Weight ____ Married ____ (Spouse's name) _____ Single ____ Occupation _____

Preferred Method of Contact: E-Mail ____ Cell ____ Home ____ Business ____

Emergency Contact _____ Phone # (____) _____

Whom may we thank for referring you to us? _____

E-Mail Address _____

Is it OK if we send you periodic E-Mails highlighting new office developments and specials or rewards for our patients? Yes ____ No ____

MEDICAL HEALTH

What is your general state of health? Excellent ____ Good ____ Fair ____ Poor ____

Name, address, and phone number of physician _____

Have you been under a physician's care during the last two years? _____

Have you been treated in the hospital in the last three years? _____

Have you had major surgery? ____ History with general or IV sedation? _____

If female; Are you pregnant or nursing? ____

Do you or have you had, any of the following? Please circle any that apply.

Epilepsy or Seizures	Irregular Heart Beat	Kidney Problems	Pneumonia
Fainting or Dizziness	Bruise/ Bleeds easily	Venereal Disease	Pacemaker
Stroke	Heart Problem	Diabetes	Nervousness/ Anxious
Persistent Cough	Chest Pain/ Angina	Thyroid Disease	Tobacco Use
Emphysema/ Bronchitis	High Blood Pressure	Aids/ HIV+	Fibromyalgia
Tuberculosis/PPD+	Rheumatic Fever	Arthritis	Dry Mouth
Asthma	Heart Murmur	Artificial Joints	Liver Disease
Sinus Problems	Mitral Valve Prolapse	Cancer	Artificial Heart Valves
Anemia/ Sickle Cell	Congenital Heart Lesions	Chemotherapy	Organ Transplants
Hepatitis A,B,C	Heart Surgery	Radiation Therapy	Other _____

Do you, or have you taken bisphosphonates (Fosamax, Actonel, Boniva)? _____ How long? _____

Are you allergic to : Penicillin, Codeine, Local Anesthetics, Other ? _____

Please list all medications you are taking, including over the counter drugs, herbs, aspirin.

Medications: _____ Dosage: _____ Times/day _____

DENTAL HEALTH

When was your last dental visit? _____
How often do you see your dentist? _____
Are you having any dental problems that require immediate attention? _____
Do you have frequent headaches? _____ Ear aches? _____ How often? _____
Is there anything that will cause your facial muscles to be tired or sore or cause headaches?

Are your jaw joints painful or tender? _____ If yes please describe

Have you had trauma to your jaw? _____ Do your jaw joints pop, click or grate? _____
Do your jaws ever feel tired or ache? _____ Have you ever been told you have TMJ? _____
Do you clench or grind or teeth? _____
Does your bite feel comfortable? _____ Have you noticed any change in your bite? _____
Have you ever been told you have periodontal disease? _____
Have you ever had periodontal treatment? _____
Do your gums bleed while brushing? _____ Do your gums ever feel tender or swollen? _____
How often do you brush your teeth? _____ Floss? _____ Water Jet? _____
Do any of the following cause tooth discomfort? Hot _____ Cold _____ Sweets _____ Chewing _____
Have you noticed any changes in your teeth? _____
Do you have loose teeth? _____ Worn teeth? _____ Broken or chipped teeth? _____ Food traps? _____
Can you chew on both sides of your mouth? _____ Comfortably? _____
Do you have loose or broken fillings? _____ Do you usually have cavities? _____
Have you ever had orthodontic treatment? (braces) _____ When? _____
Do you have any missing teeth? _____ Have they been replaced? _____
Do you have a fixed bridge? _____ Removable partial? _____ Full dentures, dental implants? _____
Are you comfortable with the replacement? _____ Please describe: _____

How do you feel about the appearance of your smile? _____
What improvements would you like to make in your mouth? _____

Please add anything you think is important: _____

CONSENT FOR SERVICES

Dr. Kaiser operates as a full-service Dentist and makes herself available to her patients with a variety of scheduling options for their busy lives.

In consideration, please cancel or reschedule any appointments with our office with at least 48 hours of notice for Dr Kaiser and her staff.

Accordingly, patients that fail to show up for their appointments, or cancel with less than 48 hour notice, will be charged a service fee proportional to the originally scheduled treatment.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any services performed without previous financial arrangements, must be paid for via cash or credit card at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient's account and that he or she is personally responsible for payment of all dental services.

This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account.

However, patients will be responsible for any remaining balance not paid for by the insurance companies.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient _____
Signature of guarantor of payment/responsible party