# CLINICAL RECORD

PLEASE PRINT CLEARLY

MS.
MISS
MR.

Today's Date ______ Marital Status ______

Name MRS ______ Age: ______ Date of Birth ______

Mailing Address ______ City ______ Zip ______ Phone ______ Cell Phone ______

Occupation ______ Employed By ______

Business Address ______ City ______ Zip ______ Phone ______

Name of Spouse ______ Spouse's Occupation ______ Date of Birth ______

Spouse Employed By ______ Business Address ______ Phone ______ Cell Phone ______

Referred By ______ Name of your dentist ______ How Long? ______

Person responsible for this account ______

**IF YOU HAVE DENTAL INSURANCE, PLEASE COMPLETE THE FOLLOWING:**

Name of Insured - Parent ☐ Patient ☐ Spouse ☐ Both ☐ IF BOTH, PLEASE COMPLETE THE PORTION BELOW

| Primary | Secondary |
|---|---|
| Primary Dental Ins. ______ | Secondary Dental Ins. ______ |
| Name of Employer ______ | Name of Employer ______ |
| Insured date of birth ______ Group # ______ | Insured date of birth ______ Group # ______ |
| Social Security # ______ | Social Security # ______ |
| Insurance Address ______ | Insurance Address ______ |

## HEALTH HISTORY

When did you last consult a physician? ______

Physician's Name ______ Phone ______

Kaiser Number ______

1. Are you being treated by a physician for any condition now? Yes ______ No ______

   If so, name the condition(s) ______

2. Date of last complete physical examination ______

3. Present state of general health: Excellent ______ ; Good ______ ; Fair ______ ; Poor ______ ;

4. List all major injuries, illnesses, operations and hospitalizations.

| Year | Disease and/or parts of body | Complications |
|---|---|---|
| | | |
| | | |
| | | |

5. List all medicines (shots, pills, etc.) which you take or are given regularly: ______

6. Do you require pre medication for dental treatment? ______

7. Are you sensitive/allergic to (Broken out in a rash from) penicillin, local anesthetics, or other drugs? YES NO

______

Name of drugs: ______

8. Are you taking any medication for your bones such as Fosomax, Aredia, or Zometa? ______

9. Are you taking aspirin or coumadin? YES NO

10. Have you had periodontal treatment in the past? YES NO How long ago? ______

11. Do you have or have you had any of the following: (Directions: If the answer is YES, put a circle around the YES. If the answer is NO, put a circle around the NO. Please answer all questions.)

| Condition | | Condition | | Medical History Up Date |
|---|---|---|---|---|
| Diabetes (sugar disease) | YES NO | Asthma | YES NO | |
| Thyroid Trouble | YES NO | Tuberculosis | YES NO | |
| Heart Trouble | YES NO | Emphysema | YES NO | |
| Rheumatic Fever | YES NO | Ulcers | YES NO | ______ |
| High Blood Pressure | YES NO | Liver Disease | YES NO | ______ |
| Bleeding Problems | YES NO | Hepatitis | YES NO | ______ |
| Anemia | YES NO | Bladder Infections | YES NO | ______ |
| Convulsions | YES NO | Kidney Infections | YES NO | ______ |
| Psychotherapy | YES NO | Pregnant NOW | YES NO | ______ |
| Hip/Knee Replaced | YES NO | Menopause | YES NO | ______ |
| Heart Valve Replaced | YES NO | Shortness of Breath | YES NO | ______ |
| Smoker | YES NO | Chest Pains | YES NO | ______ |
| HIV Positive | YES NO | Osteoporosis | YES NO | ______ |
| | | Birth Control Pills | YES NO | |