PATIENT HEALTH RECORD

Name ______________________ Date ______________________
Address ______________________ City ______________ State ______ ZIP __________
Name you wish to be called ______________________ SSN ______________ Date of Birth __________
Sex ______ Height __________ Weight __________ ☐ Single ☐ Married Spouse's Name ______________________
Cell Phone ______________ Home/Work Phone ______________ eMail ______________________
Whom may we thank for referring you to our practice? ______________________
Closest Relative/Emergency Contact ______________________ Phone ______________________

MEDICAL HEALTH

Name of physician ______________________ Phone Number ______________________
Have you been under a physician's care in the last 2 years? __________ For ______________________
Have you been treated in a hospital in the last 2 years? __________ For ______________________
Have you ever had major surgery? __________ For ______________________
If female: Are you taking Birth Control? ______ Hormones? ________ Are you pregnant? __________ Nursing? __________
Please list all medications and dosage you have taken during the past year, including prescription, non-prescription, recreational:

______________________ ______________________ ______________________
______________________ ______________________ ______________________

Are you allergic to: ☐ Latex ☐ Penicillin ☐ Local Anesthetics ☐ Codeine/Narcotics
Other (please list) ______________________

Are you taking or have you ever taken any of these? ☐ Fosamax ☐ Actonel ☐ Boniva ☐ Didronel ☐ Skelid
☐ Aredia ☐ Bonefos ☐ Zometa ☐ other Osteoporosis Drugs

Have you ever had or do you now have:

Yes	No		Yes	No	
☐	☐	Abnormal blood pressure (high or low)	☐	☐	Heart Disease or Attack
☐	☐	AIDS, ARC, HIV positive	☐	☐	Heart Murmur (Mitral Valve Prolapse, eg)
☐	☐	Allergies or Hives	☐	☐	Heart Pacemaker
☐	☐	Anemia	☐	☐	Hepatitis (Either A , B or C)
☐	☐	Angina (Chest Pains)	☐	☐	Herpes (Type I or II)
☐	☐	Anxiety	☐	☐	Implant (Joint, Eye, Breast, or other)
☐	☐	Arthritis	☐	☐	Jaundice
☐	☐	Artificial Heart Valve(s)	☐	☐	Kidney Disease
☐	☐	Artificial Joint(s)	☐	☐	Liver Disease (Jaundice, Cirrhosis)
☐	☐	Asthma	☐	☐	Organ Transplant
☐	☐	Bleeding Disorders or Taking Blood Thinners	☐	☐	Polio
☐	☐	Blood Test or Vaccination for Hepatitis	☐	☐	Prolonged Bleeding
☐	☐	Blood Transfusions	☐	☐	Prolonged Cough
☐	☐	Cancer or Tumor	☐	☐	Psychiatric Treatment
☐	☐	Cankers or Cold Sores (Mouth or Body)	☐	☐	Radiation Therapy
☐	☐	Chemotherapy	☐	☐	Rheumatic Fever
☐	☐	Congenital Heart Defect(s)	☐	☐	Sickle Cell Anemia
☐	☐	Cortisone or Steroid Treatment	☐	☐	Sinus Trouble
☐	☐	Diabetes (Adult or Juvenile Onset)	☐	☐	Special Diet
☐	☐	Drug Dependency (Pharmaceutical, Alcohol, or Tobacco)	☐	☐	Stroke
☐	☐	Emphysema	☐	☐	Thyroid Disease
☐	☐	Epilepsy or Seizures	☐	☐	Tuberculosis (TB)
☐	☐	Fainting or Dizzy Spells	☐	☐	Ulcers (Stomach, Intestine, Mouth)
☐	☐	Glaucoma	☐	☐	Veneral Disease (Sexually Transmitted)

What other disease, condition, or problem do you have that is not previously listed? ______________________

I certify that the above information is correct to the best of my knowledge. I understand I must notify Dr. Mullens, Dr. Nguyen and/or the staff immediately at any time my information changes.

Signature ______________________ Date ______________

I authorize the release of medical/dental information to any of the following if needed: My physician or other physician I am referred to, other dental offices I may be referred to, attorneys (with my prior release by signature), and my insurance company.

Signature ______________________ Date ______________

I understand Dr. Mullens and Dr. Nguyen may photograph my face and mouth for the purpose of documentation in my record. ______(Initial)

I further grant my permission to use my photographs for educating other patients, including placing them on his website and/or social media.

Signature ______________________ Date ______________