PATIENT HEALTH RECORD

Patient Information: **Date:** _____, 20____

Full Name: _____ **Male ☐ Female ☐**

Preferred Name: _____

Civic Address: _____ **Mailing Address:** _____

City: _____ **Province:** _____ **Postal Code:** _____

Patient Phone Numbers:

Home: _____ **Work:** _____ **Cellular:** _____

E-Mail Address: _____

Preferred Method of Contact: Home □ Cellular □ Work □ E-Mail □ Text □ Facebook □

Date of Birth: _____ / _____ / _____ **Health Card Number:** _____
(Day) (Month) (Year)

Occupation: _____ **Employer/School:** _____

Employer/School Address & Phone Number: _____

Insurance Information:
Policy holder: _____ Insurance Company: _____ Policy Number: _____ ID: _____

Marital Status: Single □ Married □ Common-law □ Divorced □ Widowed □ Minor □

Spouse's Name: _____ **Employer:** _____ **Work Phone #** _____

Emergency Contact: **Name:** _____ **Phone Number:** _____

Whom may we thank for referring you? _____

Dental History:

Is there a dental problem you would like treated immediately?: _____

Date of last dental visit: _____ **Reason for visit:** _____

Name of previous dentist/location: _____

Place a mark on all that apply. If you are unsure of any question, please consult the dentist.

□ Bad breath
□ Bleeding gums
□ Blisters on lips or mouth`
□ Burning feeling on tongue
□ Clenching / Grinding
□ Clicking, popping or locking jaw
□ Dry mouth
□ Fingernail biting
□ Food traps between teeth
□ Gums swollen or tender
□ Implant treatment
□ Jaw pain or tiredness
□ Lip or cheek biting
□ Loose teeth
□ Mouth breathing
□ Orthodontic treatment
□ Pain around ear
□ Pain when brushing
□ Periodontal treatment
□ Sensitivity to:
□ Hot □ Cold
□ Sweets □ Biting Pressure
□ Snoring / Sleep Apnea
□ Sores in your mouth

Do you have any prosthetic tooth replacements? □Yes □No **Are you happy with it**? □Yes □No
(denture / partial / bridge / crown, implant, etc.)

Please add anything you feel is important:

_____

_____

_____

continued on reverse ⟶

Medical History:

Physician's name: _____ **Phone number:** _____

Place a mark on all that apply to indicate if you have had any of the following:

□ AIDS / HIV
□ Anemia
□ Arthritis
□ Artificial Joints
□ Asthma
□ Autism / ADD/ADHD (circle which)
□ Bleeding Abnormally
□ Cancer: _____
□ Chemotherapy
□ Diabetes
□ Drug Dependency
□ Eating Disorder (past or present)
□ Emphysema / COPD
□ Epilepsy / Seizures
□ Fainting or dizziness
□ Glaucoma
□ Headaches / Migraines
□ Heart Murmur
□ Heart Problems
□ Hepatitis Type _____
□ High Cholesterol
□ High / Low Blood Pressure (circle which)
□ Jaundice
□ Kidney Disease
□ Liver Disease
□ Mitral Valve Prolapse
□ Organ Transplant
□ Osteoporosis
□ Pacemaker
□ Prosthetic Heart Valves
□ Psychiatric Care
□ Anxiety □ Depression □ Other
□ Radiation Treatment
□ Respiratory Disease
□ Rheumatic Heart Disease
□ Sinus trouble
□ Stroke
□ Thyroid Problems
□ Tuberculosis
□ Ulcer
□ Venereal Disease / STDs
□ ***Premedication required ?***
Reason: _____

Women Only:

□ Birth control pills?
□ Are you pregnant?
□ Are you breast feeding?

Other conditions not mentioned: _____

Current Height: _____ ***Current Weight:*** _____

Please indicate average daily consumption of the following, if applicable:

Alcohol _____ Coffee _____ Recreational Drugs _____

Tobacco _____ Tea _____ Type _____

How Long / Since When? _____

Medications/Allergies (Attach list if necessary)

Medication / dosage	**Reason for medication**	**Medication / dosage**	**Reason for medication**

Are you allergic to: □ Penicillin □ Aspirin □ Codeine □ Latex □ Other _____

This information is accurate to the best of my knowledge. I authorize the use of this information for treatment consultation with other health care practitioners or for teaching and ***I consent to the risks of dental treatment***.

_____ _____, 20___

Patient signature (*or responsible party if under 18 years of age*) Date

Insurance policy holder:

I hereby authorize release, to my insuring company plans administrator and CDANet, information contained in claims submitted electronically and for the communication of information related to the coverage of services described to **SouthWest Dental**. This authorization shall continue in effect until the undersigned revokes the same.

Signature of ***Subscriber/Policy Holder***

Date: _____, 20_____.

I hereby assign my benefits payable from claims submitted electronically to **SouthWest Dental.** and authorize payment directly to it. This authorization shall continue in effect until the undersigned revokes the same.

Signature of ***Subscriber/Policy Holder***

Date: _____, 20_____.