Patient Health Record

AMIR SEDAGHAT DDS
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DDSENDO.COM

The following information is requested to assist the Doctor in administering proper dental service. Please answer the questions to the best of your ability and use the additional space for answers requiring clarification or and additional information
Thank you for your cooperation.

☐ DR. ☐ MR. ☐ MISS ☐ MRS. Date:

NAME (Last): (First): (MI):

HOME ADDRESS:

TOWN: ZIP:

PHONE (Home): (Business):

BIRTHDATE: SEX: HEIGHT: WEIGHT:

OCCUPATION:

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED

SPOUSES NAME: PARENT/GUARDIAN:
(if under 21)

SOCIAL SECURITY NUMBER:

REFERRED BY:

PRESENT DENTIST:

Emergency information - Name, Address and Telephone No. of an individual we can call.

MEDICAL HEALTH

General Health (Please Check) ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name and address of your physician:

Last complete physical?

Are you presently under the care of a physician? ☐ Yes ☐ No

If so, for what reason?

Are you taking any medications now? ☐ Yes ☐ No

If Yes, please list all Medications.

Are you allergic to: ☐ Antibiotics ☐ Codeine ☐ Aspirin ☐ Local Anesthetics

Or any other Medications? _____

Have you ever been hospitalized? If so give name of hospital, reason and dates.

Have you had any radiological diagnostic x-rays in the last 5 years? ☐ Yes ☐ No

Have you had any blood transfusions? ☐ Yes ☐ No

Do you smoke cigarettes? ☐ Yes ☐ No How many times per day? _____

Do you consume alcohol on a daily basis? ☐ Yes ☐ No

Is your blood pressure ☐ Normal ☐ Low ☐ High

Have you experienced any recent weight change? ☐ Yes ☐ No

Women: Are you pregnant? ☐ Yes ☐ No How long? _____

Have you every had joint replacement surgery? ☐ Yes ☐ No

Do you have or have you ever been informed that you had any of the following:

Chest Pains	☐ Yes ☐ No	Postural Hypotension (fainting spells)	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No	Hypertension	☐ Yes ☐ No
Rheumatic Fever	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No
Congenital Heart Defects	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Heart Murmur (valve defect)	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No
Thyroid Problems	☐ Yes ☐ No	Hormonal Problems	☐ Yes ☐ No
Ulcers	☐ Yes ☐ No	Tuberculosis or Lung Disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Epilepsy or Seizures	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Cancer or Leukemia	☐ Yes ☐ No
Psychiatric Problems	☐ Yes ☐ No	Sickle Cell Disease	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	Prosthetic Valves or Joints	☐ Yes ☐ No
Bruise Easily	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No
Asthma or Hay Fever	☐ Yes ☐ No	Allergies or Hives	☐ Yes ☐ No
Sinus Trouble	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No
Excessive Urination and/or Thirst	☐ Yes ☐ No	Persistent Cough	☐ Yes ☐ No
Prolonged Bleeding Problems	☐ Yes ☐ No	Genetic Problems	☐ Yes ☐ No
Skin Disease	☐ Yes ☐ No	AIDS	☐ Yes ☐ No
Unexplained Fevers	☐ Yes ☐ No	Prolonged Sore Throat	☐ Yes ☐ No
Enlarged Lymph Nodes	☐ Yes ☐ No	Night Sweats	☐ Yes ☐ No
Persistent Diarrhea	☐ Yes ☐ No	Bluish-Reddish Lesions	☐ Yes ☐ No
Fatigue	☐ Yes ☐ No		

Have you ever been tested for Hepatitis? ☐ Yes ☐ No

Do you have a history of cold sores, fever blisters, or canker sores? ☐ Yes ☐ No

Are you being treated with immunosuppressive drugs? ☐ Yes ☐ No

Have you ever used drugs for recreational purposes? ☐ Yes ☐ No

CONSENT

1. I hereby authorize Dr. _____ , and any other agents or employees of _____ , and such assistants as may be selected by any of them to treat the condition(s) described below:

2. The procedure(s) necessary to treat condition(s) have been explained to me and I understand the nature of the procedure to be:

3. I have been informed of possible alternative methods of treatment including no treatment at all.

3. I have been informed of possible alternative methods of treatment including no treatment at all.

4. The doctor explained to me that there are certain inherent and potential risks in any treatment plan or procedure.

5. It has been explained to me and I understand that a perfect result is not guaranteed or warranted and cannot be guaranteed or warranted.

6. I have been given the opportunity to question the doctor concerning the nature of treatment, the inherent risks of the treatment, and the alternatives to this treatment.

7. This consent form does not encompass the entire discussion I had with the doctor regarding the proposed treatment.

8. I understand and acknowledge that I am financially responsible for the services provided for myself (or the above named) and that payment of the entire fee is due at the completion date of treatment.

Patient's Signature Date

Doctor's Signature Date

Print Form