Willow Run Dental, P.C.

Patient Health Record.

Date:_____

Name: (Last)_____(First)_____(MI)_____
Nickname:_____Address:_____
City:_____ Zip:_____ Home PH#:_____
Cell #:_____Email Address:_____
SS#_____ Date of Birth:___/___/___ Sex: M/F Marital Status S/M/W/D
Referred By:_____
Employer:_____ Work Ph#:_____
Spouse's Name: (Last)_____(First)_____(MI)_____
SS#_____ Date of Birth ___/___/___ Cell #_____
Employer:_____ Work Ph#:_____
Dental Insurance:_____Group#:_____
Name Insurance is under:_____ Ins. Ph#_____
Relationship to insured:_____

Medical Health

General health (Please check one): Excellent_____ Good_____ Fair_____ Poor_____
Name and address of Physician:_____
_____Phone #_____
Last Physical Exam:_____ Are you taking any medications now? Y/N
If 'yes', please list name and for what purpose:_____
_____.
If more space is needed, **check here**____ and use back of this page for that purpose.
Have you ever been treated for?

Heart Disease…Y/N	Heart Murmur…Y/N	Jaundice……..Y/N	Ulcers……..Y/N
Diabetes……Y/N	Epilepsy……..Y/N	Anemia…….Y/N	Cough……..Y/N
Arthritis……Y/N	Osteoporosis…..Y/N	Stroke……Y/N	Glaucoma..Y/N
Sinus trouble….Y/N	Asthma……Y/N	Hay Fever…..Y/N	HIV……..Y/N
Hepatitis A B C…….Y/N	Rheumatic Fever…Y/N	Tuberculosis….Y/N	
Lung Disease…….Y/N	Congenital Heart Lesions Y/N		

Have you had any surgery with instrumentation placed? If yes, when and what type?
_____.
Have you ever been treated (other than diagnostic) with X-Ray? Y/N if 'yes' for what purpose?
_____.
Are you allergic to: Penicillin_____ Codeine:_____ Local injected anesthetics_____
Other medications?_____
Are you subject to prolonged bleeding? Y/N Are you subject to fainting spells? Y/N
Do you have excessive urination and/or thirst? Y/N
(Women) Are you pregnant Y/N If yes, how many weeks?_____
