

Welcome to the office of **F.H. Collins III, D.D.S.**
Please fill out this patient health record as complete as possible.

PATIENT INFORMATION DATE _____
 PATIENT NAME _____ I PREFER TO BE CALLED _____
 BIRTHDATE ____/____/____ MALE ___ FEMALE ___ SINGLE ___ MARRIED ___ DIVORCED ___
 SOCIAL SECURITY # _____ EMAIL _____
 HOME PHONE# _____ CELL# _____ WORK# _____
 YOUR ADDRESS _____
 EMERGENCY CONTACT _____ RELATIONSHIP _____ PHONE# _____
 WHO REFERRED YOU TO OUR PRACTICE _____

RESPONSIBLE PARTY
 NAME RESPONSIBLE FOR ACCOUNT _____ BIRTHDATE ____/____/____
 RELATIONSHIP TO PATIENT _____ DRIVER'S LICENSE# _____
 SOCIAL SECURITY # _____ EMPLOYER _____
 HOME PHONE# _____ WORK/CELL PHONE# _____

DENTAL INSURANCE INFORMATION
 INSURANCE COMPANY NAME _____ COMPANY PHONE # _____ GROUP# _____
 INSURED'S NAME _____ EMPLOYER NAME _____
 DATE OF BIRTH ____/____/____ RELATIONSHIP TO PATIENT _____
 INSURED'S I.D. # _____ INSURED'S SOCIAL SECURITY # _____

MEDICAL HEALTH
 NAME OF PHYSICIAN _____ PHONE# _____ LAST PHYSICAL EXAM ____/____/____
 GENERAL HEALTH: EXCELLENT ___ GOOD ___ FAIR ___ POOR ___
 HAVE YOU HAD ANY SERIOUS ILLNESS OR OPERATION? _____
 HAVE YOU BEEN HOSPITALIZED WITHIN THE PAST 5 YEARS? _____
 ARE YOU TAKING MEDICATIONS? (IF SO WHAT?) _____

 ARE YOU ALLERGIC TO: PENICILLIN ___ LATEX ___ LOCAL ANESTHETICS ___ CODEINE ___ SULFA ___ NONE ___
 ANY OTHER ALLERGIES? _____
 DO YOU HAVE ANY DENTAL CONCERNS? _____ IF SO PLEASE
 EXPLAIN _____
WOMEN: ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT? YES ___ NO ___ NURSING? YES ___ NO ___

INDICATE WHICH OF THE FOLLOWING YOU HAVE HAD OR HAVE AT PRESENT. CIRCLE YES OR NO.

HEART DISEASE	YES NO	CANCER	YES NO
HEART MURMUR	YES NO	CHEMO OR RADIATION	YES NO
MITRAL VALVE PROLAPSE	YES NO	THYROID PROBLEMS	YES NO
ARTIFICIAL HEART VALVE	YES NO	KIDNEY/LIVER DISEASE	YES NO
ARTIFICIAL JOINTS	YES NO	HEPATITIS A,B,C,D,E,F,G	YES NO
INFECTIVE ENDOCARDITIS	YES NO	ASTHMA OR HAY FEVER	YES NO
HEART PACEMAKER	YES NO	ARTHRITIS	YES NO
HEART STENTS OR SHUNTS	YES NO	CONTACT LENSES	YES NO
HIGH BLOOD PRESSURE	YES NO	GLAUCOMA	YES NO
CONGENITAL HEART FAILURE	YES NO	HIV AND/OR AIDS	YES NO
RHEUMATIC FEVER	YES NO	NERVOUS DISORDERS	YES NO
ULCERS	YES NO	STROKE	YES NO
TUBERCULOSIS	YES NO	LUNG DISEASE	YES NO
DIABETES	YES NO	PROLONGED BLEEDING	YES NO
EPILEPSY	YES NO	FAINTING SPELLS	YES NO
COLD SORES/FEVER BLISTERS	YES NO	CORTISONE MEDICATIONS	YES NO

PATIENT/GUARDIAN SIGNATURE _____ **DATE** _____
DOCTOR SIGNATURE _____ **DATE** _____