my dentist
MAR & YEE DENTAL CORPORATION

Patient Health Record

In order to help me render the proper dental services to you, would you please be kind enough to answer the following questions. Please note the space for remarks for any answers that require clarification or any other information you think I should have. Thank you for your cooperation.

LAST NAME _____ FIRST _____ MIDDLE _____

HOME ADDRESS _____ CITY/STATE _____ ZIPCODE _____ ( ) HOME/CELL PHONE _____ EMAIL _____

DATE OF BIRTH _____ SEX _____ HEIGHT _____ WEIGHT _____ SSN _____ OCCUPATION/SCHOOL _____

BUSINESS NAME AND ADDRESS _____ ( ) BUSINESS PHONE _____

MARITAL STATUS _____ SPOUSE'S NAME _____ REFERRED BY _____

In case of emergency,
who would we contact?: _____
NAME _____ PHONE _____ RELATION _____

MEDICAL HEALTH

General health (please check): EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐

Name and address of physician: _____

Medical record or Kaiser number: _____ Last complete physical exam? _____

Are you taking any medications or dietary supplements ? Yes No

List medications/dietary supplements and purpose for taking them: _____

Are you now or have you ever taken Bisphosphonate Derivative, e.g. Fosamax, etc. Yes No

Have you ever been diagnosed and/or treated for: *Please circle each item*

Abnormal blood pressure	Yes	No	Heart murmur	Yes	No
Anemia	Yes	No	Hepatitis A, B, or C	Yes	No
Arthritis	Yes	No	HIV	Yes	No
Asthma or hay fever	Yes	No	Jaundice	Yes	No
Congenital heart lesions	Yes	No	Joint Replacement	Yes	No
Cholesterol	Yes	No	Orthognathic Surgery	Yes	No
Chronic Cough	Yes	No	Rheumatic Fever	Yes	No
Diabetes	Yes	No	Sinus trouble	Yes	No
Epilepsy/ Seizures	Yes	No	Stroke	Yes	No
Glaucoma	Yes	No	Tuberculosis or lung disease	Yes	No
Heart disease	Yes	No	Ulcers	Yes	No

Have you ever had radiation therapy ? Yes No

Are you allergic to: Penicillin ☐ Codeine ☐ Sulfa ☐ Vicodin ☐ Local injected anesthetics ☐

List other allergies: _____

Are you subjected to prolong bleeding ? Yes No Are you subject to fainting spells ? Yes No

Do you have excessive urination and/or thirst ? Yes No

Are you pregnant (women) ? Yes No How long ? _____

(over)

DENTAL HEALTH

Reason for visit: _____

When was your last dental visit: _____ Have you ever had any serious problems associated with previous dental treatment ? Yes No

If so, explain: _____

How often do you brush your teeth ? _____ How often do you floss your teeth ? _____

Do your gums bleed while brushing ? Yes No Do your gums bleed while flossing ? Yes No

Do you avoid brushing any part of your mouth because of pain ? Yes No If yes, what part ? _____

Do you feel twinges of pain when your teeth come in contact with:

a) Hot foods or liquids, e.g., soup, coffee, tea, etc. ? . . . . . Yes No

b) Cold foods or liquids, e.g., ice cream, cold fruit, etc. ? . . Yes No

c) Sweets, e.g., candy, fruit, sweet desserts, etc. ? . . . . . Yes No

d) Sours, e.g., lemons, limes, grapefruit, etc. ? . . . . . Yes No

Do you chew on only one side of your mouth ? . . . . . Yes No

If yes, explain: _____

Do you clench or grind your jaws while sleeping or during the day ? . . Yes No

Do you wear dentures ? . . . . . Yes No

Do you lose fillings or break fillings ? . . . . . Yes No

Do your jaws ever feel tired ? . . . . . Yes No

Do you usually have many cavities ? . . Yes No

Do you gag easily ? . . . . . Yes No

Please add anything you feel is important: _____

I understand the information that I have provided on both sides of this questionnaire is necessary. I have answered all questions truthfully and to the best of my knowledge.

_____

Patient Signature or Parent/Guardian if patient is a minor *Date*

INSURANCE INFORMATION:

INSURED'S NAME | INSURED'S SSN/DATE OF BIRTH | RELATION TO THE PATIENT

EMPLOYER BUSINESS NAME | INSURANCE CARRIER NAME/ADDRESS/PHONE

Do you have other dental coverage? Yes _____ No _____ If Yes, please complete the following:

INSURED'S NAME | INSURED'S SSN/DATE OF BIRTH | RELATION TO THE PATIENT

EMPLOYER BUSINESS NAME | INSURANCE CARRIER NAME/ADDRESS/PHONE

Your insurance company(s) will be billed as a courtesy to you via a computer generated form. It is necessary that we have your written authorization on file in our office. Kindly sign the authorization release below.

I authorized the release of information to my dental insurance company. I understand that I am responsible for payment for all costs of the dental treatment. I hereby authorize payment to the Dentist. Dental Insurance is not a guarantee of payment and the payment may be less that estimated by your insurance company.

_____

Patient Signature or Parent/Guardian if patient is a minor *Date*

I acknowledge having been provided the ***Material Safety Data Sheet and the Health Insurance Portability and Accountability Act - HIPAA***

_____

Patient Signature or Parent/Guardian if patient is a minor *Date*