Adult

JAMES C. KELLER, JR. D.D.S.
Patient Health Record

Please Print In Ink
Date

Patient Name:____Home Phone____________________

Resident Address____________________City____________________State________Zip__________

Mailing Address____________________City____________________State________Zip__________

Sex M / F Birthday______________Social Security ________________________________

Marital Status S M W D Sep Height_______Weight_________Ages of Children________________

Person Responsible for Account if Other Than Patient____________________________________

Address of Responsible Person________________________________Phone____________________

Patient's Place of Employment________________________________Business Phone______________

Business Address______________________City______________State__________Zip__________

Spouse's Place of Employment________________________________Business Phone______________

Business Address______________________City______________State__________Zip__________

Person to contact in case of emergency:______________________________Phone________________

Nearest relative not living with you______________________________Phone________________

Referred
By____

Do you have Dental Insurance? Yes / no If yes, please name Dental Insurance Company______________________

Please name Employer Covered by Dental Insurance______________________________________

PATIENT HEALTH QUESTIONS

General Health (please circle) EXCELLENT GOOD FAIR POOR

Name and Address of Physician____

Are you taking any medication now? Yes / No If yes, why?______________________________

ARE YOU ALLERGIC TO: **Penicillin** **Codeine** **Local anesthetics** **Other** medications______________________

Are you subject to prolonged bleeding? Yes / No

Are you pregnant? Yes / No If yes, expected delivery date____________________

Circle any of the following which you have had or have at present

Heart Attack/Disease	Diabetes	Asthma	Hepatitis A (infectious)
Congestive Heart Failure	Thyroid Disease	Hay Fever	Hepatitis B (Serum)
Heart Surgery/Bypass	Glaucoma	Sinus Trouble	Yellow Jaundice
Angina Pectoris	Alcohol/Drug Addiction	Cortisone	Sexual Venereal Disease
Heart Pacemaker	Liver Disease	Corticosteriod Treatment	Osteoporosis
Heart Murmur	Kidney/Bladder Trouble	Arthritis	Emphysema
Rheumatic Fever	Cancer	Artificial Joint	Tuberculosis (TB)
Scarlet Fever	Chemotherapy	AIDS/HIV Positive	Nervousness
Arteriosclerosis	Xray or Cobalt Treatment	Blood Transfusion	Psychiatric Treatment
Mitral Valve Prolapse	Fainting/Dizzy Spells	Anemia	Stomach Ulcer
Stroke	Epilepsy/Seizures	Hemophilia	Other:
High Blood Pressure	Allergies/Hives	Sickle Cell Disease	____________________

DENTAL HEALTH--Reason for visit____

AUTHORIZATION

I grant authority to the dentist to perform procedures and treatment, including administration of medication, local and general anesthetics, and extractions along with other surgical and dental procedures that may be necessary.
I/We agree to pay collection cost and/or a reasonable attorney's fee if any delinquent balance is placed with an agency or attorney for collection or suit. Any account with a balance over 60 days will be subject to an 18% APR finance charge.
I hereby, assign any insurance benefits to be made directly to the dentist, and understand that I am responsible to pay any amount not covered by insurance.
To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if may medicines change, I will inform the dentist at the next appointment without fail.

Date______________________**Signature**____