Patient Periodic Update

Harris Southwest Dental

Last Name _____ First Name _____ MI _____ Date of Birth _____ Age ____
Sex M or F Soc. Sec. # _____ Please Circle One: Single Married Separated Widow
Mailing Address _____ City _____ State ____ Zip Code _____
Home Phone (_____)_____ Cell Phone (_____)_____ Email _____
Occupation _____ Employer _____
Work Phone (_____)_____ Driver's License # _____
Are you a full time student? Yes or No If Patient is a minor: Mother's DOB _____ Father's DOB _____
Name of Parent _____ Parent Soc. Sec. # _____
Parent Employer _____ Parent Phone (_____)_____
Person Responsible for Account _____ Relationship _____
Emergency Contact _____ Relationship _____ Phone # (_____)_____
If you are filling this form out on behalf of another person, what is your relationship to that person?
Name _____ Relationship _____

Medical History - Please mark (x) to your response to indicate if you have or have had any of the following

Cardiovascular
- ☐ Angina (chest pain)
- ☐ Artificial Heart Valve
- ☐ Heart Conditions
- ☐ Heart Surgery
- ☐ High/Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke

Cancer: Type _____
- ☐ Chemotherapy
- ☐ Radiation Therapy

Endocrinology
- ☐ Diabetes
- ☐ Hepatitis A/B/C
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Thyroid Disease

Gastrointestinal
- ☐ Ulcers (Stomach)
- ☐ Gastrointestinal Disease

Viral Infections
- ☐ AIDS
- ☐ HIV Positive
- ☐ HPV

Respiratory
- ☐ Asthma
- ☐ Emphysema
- ☐ Respiratory Problems
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Tuberculosis

Hematologic/Lymphatic
- ☐ Anemia
- ☐ Blood Disorders
- ☐ Bruise Easily
- ☐ Excessive Bleeding

Women
- ☐ Currently Pregnant
- ☐ Nursing

Musculoskeletal
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Jaw Joint Pain
- ☐ Rheumatoid Arthritis

Neurological
- ☐ Anxiety
- ☐ Depression
- ☐ Dizziness
- ☐ Drug/Alcohol Addiction
- ☐ Fainting
- ☐ Seizures
- ☐ Psychiatric Illness

Are you under the care of a physician? Y or N If yes, please explain _____
Physician Name_____Address:_____Phone(_____)_____
Have you had a serious illness, operation, or hospitalization in the past 5 years? Y or N, If yes please explain _____
_____
Are you taking or have you recently taken any prescription or over the counter medicine(s)? Y or N If yes, please list all and why, including vitamins, natural or herbal supplements and/or dietary supplements _____
_____

List all Medications or Substitutes you are Allergic to: _____
_____
_____
_____

Have you ever in the past, or are you now currently taking any medications for Osteopenia/Osteoporosis or Bone Disease? If so, please list medications: _____
_____
_____
_____

Have you ever had surgery? If so, what type: _____
_____
_____
_____
_____
_____

Consent:

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.

_____ _____ _____
Signature of Patient/Legal guardian **Date** **Dentist Signature**

For completion by dentist only | Additional Comments
_____
_____

0C126_0600165