ANTHONY J. LADDS, D.D.S., PLLC
PATIENT HEALTH RECORD

In order to help us render the proper dental services to you,
please answer all of the following questions.
All information will be kept confidential unless its release is requested by the patient or guardian.
Thank you.

Date: ____________________

Patient's Name: ____________________ Phone # ____________ Cell # ____________

Preferred Contact: ☐ Phone ☐ Cell ☐ Email Emergency Contact #____________________

Address:____________________ email: ____________

Date of Birth: ____________ S.S.# ____________ Wt.: ____________ Ht.: ____________

Sex: Male: ______ Female: ______Marital status: Single: ________ Married: ________ Widowed:________

Patient's business name & address: ____________________

Patient's occupation: ____________________ May we call you at work? ________ Phone # ____________

If married, spouse's name: ____________________

Spouse's business name and address: ____________________

Name of Dental Insurance: ____________________ Group #:____________

Name of employee that has coverage: ____________________ S.S. # of policyholder:____________

Whom may we thank for recommending our office to you? ____________________

Name of financially responsible party:____________________

IF MINOR, FILL OUT THE FOLLOWING 5 (FIVE) LINES:

Mother's name: ____________________

Mother's business name and address: ____________________

Father's name:____________________

Father's business name and address:____________________

If full time student name of school attending:____________________

DENTAL HISTORY

Reason for today's visit? ____________________

Date of last dental visit? ____________ Date of last cleaning?____________

Are you wearing a denture or removable appliance? ____________________

Do you clench or grind your teeth? ____________________

Do you have sensitivity to hot, cold, sweets, or pressure? ____________ If yes, area ____________

How often do you brush? ____________ floss? ____________

Are you presently taking fluoride tablets or using a fluoride rinse? ____________________

Name of previous Dentist: ____________ Why did you leave? ____________

Have you ever had any serious problem associated with previous dental treatment?____________

(Continued on back)

MEDICAL HISTORY

General Health: Excellent: ____________ Good: ____________ Fair: ____________ Poor: ____________

Name and address of physician: ____________

Last complete physical: ____________

Are you presently under the care of your physician? ________ If yes, why? ____________

Have you had any recent illness? ______ If so, explain ____________

Are you presently taking any medications? _____ If so, please list ____________

Do you use tobacco products? ____________

Do you drink alcohol? ____________

(Women) Are you pregnant? ____________

History of emotional stress? ____________

Are you subject to fainting spells? ____________

Please √ yes or no for each of the following:

Blood pressure: High: __________ Low: __________ Normal: __________

Acquired Immune Deficiency Syndrome: Yes ____ No ____

Positive antibody test (AIDS): Yes ____ No ____

Anemia: Yes ____ No ____

Arthritis: Yes ____ No ____

Asthma: Yes ____ No ____

Cancer: Yes ____ No ____

If cancer, explain: ____________

____

____

If hospitalized in last 5 years, explain: ____________

____

Treatment with Chemotherapy/ Radiation Therapy: Yes ____ No ____

Date of last treatment ____________

Diabetes: Type ____________ Yes ____ No ____

Eating Disorder: Yes ____ No ____

Epilepsy: Yes ____ No ____

Glaucoma: Yes ____ No ____

Hearing Impairment: Yes ____ No ____

Heart Attack: Yes ____ No ____

Heart Disease: Yes ____ No ____

Heart Murmur: Yes ____ No ____

Congenital Heart Lesions/Disease: Yes ____ No ____

Heart or valvular surgery: (open heart, by-pass, etc.) Yes ____ No ____

Mitral Valve Prolapse: Yes ____ No ____

Sub Acute Endocarditis: Yes ____ No ____

Rheumatic Fever: Yes ____ No ____

Pacemaker: Yes ____ No ____

Hepatitis: Yes ____ No ____

Jaundice: Yes ____ No ____

Kidney History: Yes ____ No ____

Liver: Yes ____ No ____

Lung Disease: Yes ____ No ____

Prolonged Bleeding: Yes ____ No ____

Prosthetic Joint Replacement: Yes ____ No ____

Shingles: Yes ____ No ____

Sight Impairment: Yes ____ No ____

Sinus Trouble: Yes ____ No ____

Stroke: Yes ____ No ____

Tuberculosis: Yes ____ No ____

Ulcers: Yes ____ No ____

STD: Yes ____ No ____

Are you allergic to or have you reacted adversely to:

Local injected anesthetics: ______ Penicillin ____________ Codeine ____________ Sulfa Drugs ____________

Aspirin ____________ Epinephrine ____________ Any Other ____________ None of these ____________

Do you have any other disease, condition, major surgery, or problem not listed above? ____________

If so, explain: ____________

Any additional information: ____________

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____

Signature of patient or responsible party: ____________