Dr. Jeffrey S. Harris, D.M.D., P.C.
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HARRIS DENTAL ARTS

Our goal is to help each of our patients reach and maintain the maximum oral health possible. We achieve this by examination, treatment and education. The commitment we have to each patient is to provide care with the latest state of the art equipment and techniques.

Please fill out these forms completely so that we can better care for you.

ABOUT YOU

Today's date:

Name:

MR MRS MS DR FIRST MI LAST

I prefer to be called:

Birthdate: Age: SS#:

Home Address: APT/CONDO#

City: State: Zip:

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home Phone: Cell Phone:

Work Phone: Ext#: Fax:

Email Address:

Employer: Employer's Address:

How long there? Occupation:

Who may we thank for referring you? Other family members seen by us?

Who will pay this Account? Signature:

If using Credit Card: Name: Card Number:

Signature: Exp. Date:

By signing above, I authorize any unpaid balance on my account to be charged to my credit card above.

SPOUSE INFORMATION

Name:

FIRST MI LAST

Employer:

Work Phone: Ext#: Cell#:

Birthdate: SS#:

EMERGENCY INFORMATION

In the event of an emergency, is there someone who lives near you that we should contact?

Name: Relation:

Home Phone: Cell Phone:

Work Phone: Ext#:

DENTAL HISTORY

Why have you come to the dentist?

Are you currently in pain? ☐ No ☐ Yes

Have you ever had a serious | difficult problem associated with any previous dental work? ☐ No ☐ Yes

Do you now or have you ever experienced pain | discomfort in your jaw joint? (TMJ | TMD)? ☐ No ☐ Yes

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ No ☐ Yes

Why or why not?

Do your gums ever bleed? ☐ No ☐ Yes

# of times a week you floss? _____ # of times a day do you brush? _____

Type of bristles: ☐ Hard ☐ Medium ☐ Soft

Previous | Present Dentist (PLEASE CIRCLE)

Last Visit Date:

Last Cleaning Date:

Last X-Rays:

MEDICAL HISTORY

Physician's Name: Phone #:

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ No ☐ Yes

Please explain:

Are you taking any prescription | over the counter drugs? ☐ No ☐ Yes

Please list any medications:

Are you currently taking any bone density medication? ☐ No ☐ Yes

Please list any medications:

Do you smoke or use tobacco in any form? ☐ No ☐ Yes

Have you ever been hospitalized? ☐ No ☐ Yes

If so, for what?

Do you need antibiotic premedication for rheumatic fever, heart murmur or artificial prosthesis, before dental treatment? ☐ No ☐ Yes

For women, are you taking birth control pills? ☐ No ☐ Yes

Are you pregnant? Week#: _____ ☐ No ☐ Yes

Are you nursing? ☐ No ☐ Yes

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MEDICAL HISTORY

Have you ever had any of the following diseases or medical problems? Circle yes or no.

Y	**N**	Heart Attack | Stroke	**Y**	**N**	High | Low Blood Pressure	**Y**	**N**	Sleep Apnea
Y	**N**	Cancer | Chemotherapy	**Y**	**N**	Fever Blisters	**Y**	**N**	Congenital Heart Defect
Y	**N**	Heart Murmur	**Y**	**N**	Severe | Frequent Headaches	**Y**	**N**	Anemia
Y	**N**	Rheumatic Fever	**Y**	**N**	Pyschiatric Problems	**Y**	**N**	Radiation Treatment
Y	**N**	HIV+ | AIDS	**Y**	**N**	Epilepsy | Seizures | Fainting	**Y**	**N**	Asthma
Y	**N**	Heart Surgery | Pacemaker	**Y**	**N**	Diabetes	**Y**	**N**	Arthritis
Y	**N**	Shingles	**Y**	**N**	Tuberculosis	**Y**	**N**	Difficulty Breathing
Y	**N**	Mitral Valve Prolapse	**Y**	**N**	Drug | Alcohol Abuse	**Y**	**N**	Hepatitis
Y	**N**	Kidney Problems	**Y**	**N**	Venereal Disease	**Y**	**N**	Blood Transfusion
Y	**N**	Artificial Bones | Joints	**Y**	**N**	Hemophilia | Abnormal Bleeding	**Y**	**N**	Emphysema
Y	**N**	Artificial Valves	**Y**	**N**	Ulcers | Colitis	**Y**	**N**	Glaucoma
Y	**N**	Sinus Problems						

Please list any serious medical condition(s) that you have ever had:

Are you allergic to any of the following? Circle yes or no.

Y	**N**	Penicillin	**Y**	**N**	Erythromycin	**Y**	**N**	Latex
Y	**N**	Aspirin	**Y**	**N**	Codeine	**Y**	**N**	Other
Y	**N**	Tetracycline	**Y**	**N**	Dental Anesthetics			

Please list any other drugs that you are allergic to:

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.

Payment is due in full at the time of treatment unless prior arrangements have been approved.

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

Signature: _____ Date: _____

OFFICE USE ONLY

I verbally reviewed the medical | dental information above with the patient named herein. Initial: _____ Date: _____

Penicillin Allergy: ☐ No ☐ Yes

Aspirin Sensitivity: ☐ No ☐ Yes

Food, Other medications allergies: ☐ No ☐ Yes

Medications presently taking:

Hospitalization dates and surgeries:

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Please use this form if you need additional room to supply medical information.

Patient Name: _____

Date of Birth: _____

Today's Date: _____

Medications: *(name, dosage, frequency)*

_____

_____

_____

_____

_____

_____

Surgeries: *(date, surgery, area)*

_____

_____

_____

_____

_____

Any other pertinent medical information?

_____

_____

_____