Patient Health Record
Welcome to the office of Robert F. Murray, D.D.S.

In order for me to render the proper dental services, please answer the following questions. Please note the space for remarks, clarification or any other information you think I should have to serve you. Thank you.

Patient Information

Date _____

Home Phone #_____

Name_____Cell Phone # _____
Last Name First Name Initial

Address_____Email _____

City_____**Soc. Sec. #**_____

State _____ Zip _____ Sex M ___ F ___ Age _____ Birth Date _____

Circle: Single____ Married____ Widowed____ Separated ____ Divorced____ Student __ FT __ PT __

Patient Employed by _____ Occupation_____ Name of School _____

Business Address _____ Business Phone # _____

Whom may we thank for referring you? _____

In case of emergency, who should be notified? _____ Phone # _____

Responsible (who pays your bills?)

Name of Person Responsible for this account _____ Relationship to patient _____

Address _____ Home Phone # _____

Drivers License #_____State ___ Employer _____ Business Phone # _____

Financial Institution _____ Birth Date _____ **Soc. Sec. #**_____

Medical Health

General Health Excellent Good Fair

Name of Physician _____ Phone # _____ Last complete physical _____/_____/_____

Are you under the care of a physician now? Yes ____ No _____ If yes, describe the purpose _____

Are you taking medication now? (If so, what?) _____

Are you allergic to: Penicillin □ Local anesthetics □ Any other medications? _____

For office use:

Have you had any serious illness or operation? _____ HH-Update: _____ _____ _____ _____

Have you been hospitalized in the past five years? _____ _____ _____ _____ _____

Women are you pregnant? Yes □ No □ How many months? _____ _____ _____ _____ _____

Check if you have ever been told or treated for any of the following conditions:

Heart disease	Yes □	No □	Tuberculosis or lung disease	Yes □	No □	Sinus trouble	Yes □	No □
Heart murmur/MVP	Yes □	No □	Diabetes	Yes □	No □	Latex Allergy	Yes □	No □
Artificial Heart Valve	Yes □	No □	Controlled	Yes □	No □	Arthritis	Yes □	No □
Artificial Joints	Yes □	No □	How often? _____			Glaucoma	Yes □	No □
Stroke	Yes □	No □	Epilepsy	Yes □	No □	Nervous disorders	Yes □	No □
Pacemaker	Yes □	No □	Cancer	Yes □	No □	Prolonged bleeding	Yes □	No □
Rheumatic fever	Yes □	No □	Thyroid	Yes □	No □	Fainting spells	Yes □	No □
High blood pressure	Yes □	No □	Kidney/Liver Disease	Yes □	No □	Chemical Dependency	Yes □	No □
Congenital heart lesions	Yes □	No □	Hepatitis	Yes □	No □	HIV and/or AIDS	Yes □	No □
Ulcers	Yes □	No □	Asthma or Hay Fever	Yes □	No □	Bisphosphonates	Yes □	No □