



**Harmony dental**

Family. Integrity. Health.

8430 SW Nimbus Ave, Suite 300

Beaverton OR 97008

PHONE 503-639-6900 • FAX 503-684-8167

### PATIENT INFORMATION

Completion of this information in its entirety is required at time of visit.

A. Name \_\_\_\_\_ Social Security # \_\_\_\_\_ DOB \_\_\_\_\_  
Last First Middle

Home Address \_\_\_\_\_  
Street City State Zip Code

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Address \_\_\_\_\_ Work Phone \_\_\_\_\_  
Street City State Zip Code

Marital Status (check one): Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_ Domestic Partner \_\_\_\_\_

Spouse/Parent \_\_\_\_\_ Social Security # \_\_\_\_\_ DOB \_\_\_\_\_ Phone \_\_\_\_\_

Home Address \_\_\_\_\_  
Street City State Zip Code

Spouse Employer \_\_\_\_\_ Address \_\_\_\_\_ Work Phone \_\_\_\_\_

**B. If someone other than the PATIENT is responsible for payment, complete the following:**

Name of the responsible party \_\_\_\_\_ Address \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Social Security # \_\_\_\_\_ Home Phone \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_ Work Phone \_\_\_\_\_

**C. In case of EMERGENCY (specify someone who does not live in your household):**

Relative to contact (other than spouse) \_\_\_\_\_ Phone \_\_\_\_\_

Other Person to contact (not relative) \_\_\_\_\_ Phone \_\_\_\_\_

**D. Insurance:**

Primary Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_ Phone \_\_\_\_\_

Name of Insured \_\_\_\_\_ Patient ID # \_\_\_\_\_

Secondary Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_ Phone \_\_\_\_\_

Name of Insured \_\_\_\_\_ Patient ID # \_\_\_\_\_

**E. Please sign and return to the receptionist.**

*I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all legal costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure payment.*

Signature \_\_\_\_\_ Date \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU? \_\_\_\_\_

# HEALTH HISTORY

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis Type: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally, with extractions or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Feet or Ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or growth on head or neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, persistent or bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss, unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you wear contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No		

## Women:

Are you pregnant?  Yes  No Due Date \_\_\_\_\_ Are you nursing?  Yes  No

Taking birth control pills?  Yes  No

## MEDICATIONS

List any medications you are currently taking and the correlating diagnosis: \_\_\_\_\_

Pharmacy Name \_\_\_\_\_  
Pharmacy Phone \_\_\_\_\_

## ALLERGIES

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Local Anesthetic
<input type="checkbox"/> Barbiturates (sleeping pills)	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Codeine	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Iodine	<input type="checkbox"/> Other _____
<input type="checkbox"/> Latex	_____

## DENTAL HISTORY

Reasons for today's visit \_\_\_\_\_

Former Dentist \_\_\_\_\_

City/State \_\_\_\_\_

Date of last dental visit \_\_\_\_\_

Date of last dental X-rays \_\_\_\_\_

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No

Burning sensation on tongue	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chew on one side of mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain, brushing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cigarette, pipe, or cigar(smoking)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Clicking or popping jaw	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dry mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fingernail biting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold	<input type="checkbox"/> Yes <input type="checkbox"/> No
Food collection between teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat	<input type="checkbox"/> Yes <input type="checkbox"/> No
Foreign objects	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets	<input type="checkbox"/> Yes <input type="checkbox"/> No
Grinding teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gums swollen or tender	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in your mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Jaw pain or tiredness	<input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____	
Lip or cheek biting	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Loose teeth or broken fillings	<input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you brush? _____	
		_____	

I acknowledge that the health history and information provided on this form is correct and has been updated to the best of my knowledge.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_