MOUNTAIN RIDGE DENTISTRY

Patient Health Information

General Information	
First and Last Name:	
Preferred Name:	
Date of Birth:	
Emergency contact name:	
Emergency contact phone:	
Spouse's Name: (if married)	
Physician Name:	

Contact Information	
Cell/Home Phone:	
Address:	
City:	
State:	
Zip:	

Employment Information	
Employer:	
Work Phone:	

Optional HIPAA Contact	
To authorize someone to have access to your privileged HIPAA health information, please provide their information below. **Leave this blank if you do not wish to authorize anyone**.	
First and Last Name:	
Relationship:	
Birthday (verification purposes):	
Phone Number:	

Medical History	
	Cancer, tumor, radiation treatment (circle all that apply)
	Heart ailment or angina (circle one)
	Heart murmur, mitral valve, heart defect (circle one)
	Rheumatic fever or rheumatic heart disease (circle one)
	Artificial joint or valve (circle one)
	High or low blood pressure (circle one)
	Pacemaker
	Tuberculosis or lung problems (circle one)
	Kidney disease
	Hepatitis or other liver disease (circle one)
	Alcoholism
	Blood transfusion
	Diabetes
	Neurologic condition
	Epilepsy, seizures, or fainting spells (circle one)
	Emotional condition
	Arthritis
	Herpes or cold sores (circle one)
	AIDS or HIV positive (circle one)
	Migraine headaches / frequent headaches (circle one)
	Anemia or blood disorders (circle one)
	Abnormal bleeding after extractions, surgery, or trauma (circle one)
	Hayfever or sinus trouble (circle one)
	Allergies or hives (circle one)
	Asthma
	Comments / Additional Conditions:

_____

Patient/Responsible Party Signature

_____

Date

310 Mountain Avenue, Berthoud CO 80513 ~ 970.528.0900 ~ **mountainridgedentistry.com**

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Patient Health Information

Page Two

Current Health
Do you use tobacco? (Please specify: chew, smoke, vape, etc.)
Do you use alcohol? If so, how frequently?
List ALL Allergies:
List ALL Current Medications and Prescriptions (include over the counter medications):
Pregnant? Y N

Dental Health
Do you clench or grind your teeth? Y N *Optional explanation:*
Do your gums ever bleed? Y N *Optional explanation:*
How do you feel about visiting the dentist?
Anything else not listed on this sheet?

_____

Patient Printed Name

_____ _____

Patient/Responsible Party Signature **Date**

We protect and encrypt your information to ensure confidentiality.

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