



JOHN T. BAILEY, D.M.D.

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Update Patient Health Record

Patient Information

Date _____

Name _____ M / F SSN _____

Address _____ City _____ Zip _____

Home phone _____ Cell phone _____ Email _____

Work/day phone _____ Employer _____

Employer address _____

Birth date _____ Name of spouse _____ Cell _____

Someone (other than spouse) we could contact in case of emergency _____

Relationship _____ Their day phone _____ Cell _____

Person who is responsible for this account _____

Dental insurance policy holder's name? _____ SSN _____

Policy holder's employer _____

Whom may we thank for referring you to our office? _____

Medical Information

Are you in good health? Yes No (Females) Are you pregnant or nursing? Yes No

Name of Physician _____ Physician phone _____

Reason for last visit _____

Please list all medications _____

Do you have or have you had any of the following?

Abnormal blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dementia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy to any drug	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prolonged bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prolonged cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial heart valve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial joint	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bacterial endocarditis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood thinners	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Taking Aspirin daily	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Immune system problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tobacco use	<input type="checkbox"/> Yes <input type="checkbox"/> No
Canker/Cold sores	<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
Colitis	<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
Congenital heart lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Organ transplant	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please use this space to add any other information you feel is important _____



Signature



Date