HEALTH QUESTIONNAIRE

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care.

Please answer each question. Check the appropriate box and/or circle **Yes** or **No** where applicable. Example: Are you alive? .... (Yes) No

MEDICAL HISTORY

1. Are you in good health? .... Yes No
2. Date of last physical examination ____________________
3. Are you now under the care of a physician? .... Yes No
   If so, what is the condition being treated? ____________________
4. Have you ever had any serious illness or operation? .... Yes No
   If so, what illness or operation? ____________________
5. Have you ever been hospitalized? .... Yes No
   If so, what was the problem? ____________________
6. Are you taking any ❑ medications, ❑ drugs or ❑ herbs? .... Yes No
   If so, what? ____________________ What dosage? ____________________
7. Are you using any recreational drugs (marijuana, cocaine, etc.)? ❑ Yes ❑ No If so, what? ____________________
8. Have you ever been premedicated with antibiotics for your dental treatment? .... Yes No
9. Are you sensitive or allergic to any drugs or materials? ❑ Penicillin; ❑ Tetracycline; ❑ Sulfa Drugs; ❑ Aspirin; ❑ Codeine; ❑ Latex; ❑ Other .... Yes No
   If Other, what drugs? ____________________
10. Do you have or have you had any of the following: (Please circle 'Y' for Yes or 'N' for No - answer all conditions):

Y N Anemia	Y N Hemophilia	Y N Heart Murmur	Y N Tuberculosis (T.B.)	Y N Cortisone Medicine	Y N Heart Ailments or Attack
Y N Herpes	Y N Cold Sores	Y N Liver Disease	Y N Rheumatic Fever	Y N Allergies to Metals	Y N Congenital Heart Lesions
Y N Stroke	Y N Emphysema	Y N Blood Disease	Y N Blood Transfusion	Y N Excessive Bleeding	Y N X-Ray or Cobalt Treatment
Y N Ulcers	Y N Rheumatism	Y N Drug Addiction	Y N Joint Replacement	Y N High Blood Pressure	Y N Fainting Spells or Seizures
Y N Diabetes	Y N Chicken Pox	Y N Kidney Disease	Y N Nervous Disorders	Y N HIV Related Complex	Y N Chemotherapy
Y N Glaucoma	Y N Bruise Easily	Y N Stomach Ulcers	Y N Tumors or Growths	Y N Respiratory Disease	Y N Radiation Treatment of any kind
Y N Arthritis	Y N Head Injuries	Y N Angina Pectoris	Y N Allergies or Hives	Y N Epilepsy or Seizures	Y N Venereal Disease (Syphilis, Gonorrhea)
Y N Hay Fever	Y N Heart Failure	Y N Mental Disorder	Y N Pain in Jaw Joints	Y N Psychiatric Treatment	Y N Acquired Immune Deficiency Syndrome (AIDS)
Y N Tonsillitis	Y N Scarlet Fever	Y N Cerebral Palsy	Y N Artificial Prosthesis	Y N Hepatitis or Jaundice	Y N TMJ (Temporomandibular Joint) Disorder
Y N Asthma	Y N Sinus Trouble	Y N Thyroid Disease	Y N Sickle Cell Disease	Y N Difficulty in Swallowing	Y N Cancer

11. Do you have any disease, condition or problem not listed that you think we should know about? .... Yes No
    If so, what? ____________________
12. Do you wear a cardiac pacemaker, or have you had heart surgery? .... Yes No
13. Do you smoke? If yes, how much? ❑ Cigarettes ❑ Cigars ❑ Packs per day .... Yes No
14. Have you ever taken the drugs ❑ Phen-Phen, ❑ Redux or any ❑ diet drugs? .... Yes No
15. (Women) Are you pregnant? If so how many months? ____________________ Yes No
16. (Women) Do you have any problems associated with your menstrual period? .... Yes No
17. (Women) Do you take any birth control medication or hormones? .... Yes No

DENTAL HISTORY

1. Have you ever had a local anesthetic (Novocaine, etc.)? .... Yes No
2. Have you ever had any unfavorable reaction from a local anesthetic? .... Yes No
3. Have you had any serious trouble associated with any previous dental treatment? .... Yes No
   If so, explain? ____________________
4. How long since your last full mouth X-Rays? _____ Weeks _____ Months _____ Years
5. How long since your last dental treatment? _____ Weeks _____ Months _____ Years
6. Does dental treatment make you nervous? ❑ Slightly ❑ Moderately ❑ Extremely? .... Yes No
7. Would you desire to be pre-sedated? .... Yes No

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or if my medications change, I will, without fail, inform the doctor at my next appointment.

A Date __________ **Signature** ____________________

B UPDATE — Since your last visit:

1. Have you seen a medical doctor? .... Yes No
2. Have you had a change in your medication? .... Yes No
3. Have you had a change in your medical condition or had surgery? .... Yes No

Please note changes in health since last visit. If no changes, please write "None"

____

Date __________ **Signature** ____________________

C UPDATE — Since your last visit:

1. Have you seen a medical doctor? .... Yes No
2. Have you had a change in your medication? .... Yes No
3. Have you had a change in your medical condition or had surgery? .... Yes No

Please note changes in health since last visit. If no changes, please write "None"

____

Date __________ **Signature** ____________________

REVIEWED BY — ***DO NOT WRITE IN THIS SPACE***

A ______ DATE ______
B ______ DATE ______
C ______ DATE ______

	A	B	C
DATE			
B.P.	/	/	/
PULSE			
TEMP			
BY			

HEALTH QUESTIONNAIRE MUST BE CONTINUALLY UPDATED!

CONSENT FOR TREATMENT: I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

All services are rendered and accepted under the terms and conditions printed on the reverse hereof:

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or wher[illegible]e patient is physically or mentally incompetent.

Signed: ____________________ **Date:** __________ **Re[illegible]onship to Patient** __________

PATIENT INFORMATION

(This information is necessary for our files and will be considered ***CONFIDENTIAL****)*

Date ____________

Patient's Name ____________ LAST FIRST INITIAL Age ______ Patient's Birthday ____________ ❑ Male ❑ Female

If patient is a minor, give name of parent or legal guardian ____________ Relationship ____________

Residence Address ____________ STREET CITY ZIP For how long? ______ ❑ Own ❑ Rent

Patient is: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed ❑ Minor Email ____________

Driver's License No. ____________ Social Security No. ____________ Res. Phone (______) ____________

Bank ____________ Account No. ____________ How long? ____________

Employed by ____________ How long? ______ Occupation ____________

Business Address ____________ STREET CITY ZIP Bus. Phone (______) ____________

Spouse's Name ____________ Driver's License No. ____________ Soc. Sec. No. ____________

Employed by ____________ How long? ______ Occupation ____________

Business Address ____________ STREET CITY ZIP Bus. Phone (______) ____________

Name of nearest relative not living with you ____________ Relationship ____________

Complete Address ____________ STREET CITY ZIP Res. Phone (______) ____________

Name of Physician ____________ ADDRESS CITY ( ) TELEPHONE ❑ I have no physician

Former Dentist ____________ ADDRESS CITY ( ) TELEPHONE

Why are you changing dentists? ____________

Purpose of Appointment ____________

Is this office visit for Emergency Dental Care? ❑ Yes ❑ No If yes, explain: ____________

School Children Attend ____________ Whom may we thank for referring you? ____________

FINANCIAL INFORMATION

Person responsible for this account ____________ Relationship ____________

Address ____________ STREET CITY ZIP ( ) TELEPHONE

PREFERENCE OF PAYMENT: ❑ Cash on day of treatment ❑ Visa No. ____________ EXPIRATION DATE

❑ State Aid No. ____________ ❑ Mastercard No. ____________ EXPIRATION DATE

Name of insurance company (primary insurance) ____________

INSURED PERSON'S NAME BIRTHDATE RELATIONSHIP SOCIAL SECURITY NO

NAME OF GROUP DENTAL PLAN GROUP NO PLAN NO NAME OF UNION LOCAL

Name of insurance company (secondary insurance) ____________

INSURED PERSON'S NAME BIRTHDATE RELATIONSHIP SOCIAL SECURITY NO

NAME OF GROUP DENTAL PLAN GROUP NO PLAN NO NAME OF UNION LOCAL

TERMS & CONDITIONS

As a condition of treatment by this office, I understand financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for in cash at the time services are performed.

I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of Insurance: I hereby authorize my insurance company to pay directly to my dentist benefits accruing to me under my policy.

A service charge of $1\frac{1}{2}\%$ per month (18% per annum) (but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within 60 days of treatment date.

I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of the patient's examination.

In consideration of the professional services rendered to me, or at my request, by the Doctor and/or his staff, I agree to pay, therefore, the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to by me, in writing, within the time for payment thereof. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's and/or collection fees.

I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content:

Signed ____________ Date ____________