

**STEVEN R. CHEW, D.D.S.      PAUL R. MURRAY, D.M.D.**

GENERAL, ESTHETIC, AND IMPLANT DENTISTRY

We are complimented that you have selected us to provide dental care for you and your family.  
So that we can serve you better please complete both sides of this new patient information and health history form.

## PATIENT INFORMATION AND HEALTH HISTORY

Patient's Name \_\_\_\_\_ Age \_\_\_\_\_ Spouse's name \_\_\_\_\_  
If patient is a minor, give parent's or guardian's name \_\_\_\_\_  
Residence Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
 Married     Single     Divorced     Separated     Widowed  
Driver's License No. \_\_\_\_\_ Social Security No. \_\_\_\_\_ Res. Phone \_\_\_\_\_  
Your Birthdate \_\_\_\_\_  
Employed by \_\_\_\_\_ Occupation \_\_\_\_\_  
Business address \_\_\_\_\_ Bus. Phone \_\_\_\_\_  
Spouse Employed by \_\_\_\_\_ Occupation \_\_\_\_\_  
Business Address \_\_\_\_\_ Bus. Phone \_\_\_\_\_  
Name of nearest relative not living with you \_\_\_\_\_ Relationship \_\_\_\_\_  
Complete Address \_\_\_\_\_ Res. Phone \_\_\_\_\_  
Name of Physician \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_  
Former Dentist \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_  
Purpose of Appointment \_\_\_\_\_  
Is this office visit for Emergency Dental Care? \_\_\_\_\_  
School Children Attend \_\_\_\_\_  
\_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

### FINANCIAL INFORMATION

Person responsible for this account \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_

### PREFERENCE OF PAYMENT

Cash on day of treatment \_\_\_\_\_ Dental Insurance (Name of Co.) \_\_\_\_\_  
BankAmericard No. (VISA) \_\_\_\_\_ Insurance Group No. \_\_\_\_\_  
Mastercharge No. (Mastercard) \_\_\_\_\_ Soc. Sec. No. of Insured \_\_\_\_\_  
Other: \_\_\_\_\_

COMMENTS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PLEASE COMPLETE REVERSE SIDE

# HEALTH QUESTIONNAIRE

Please answer each question. 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 \_\_\_\_\_ Yes No
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 drugs or medicine? ..... Yes No  
If so, what? \_\_\_\_\_ What dosage? \_\_\_\_\_
7. Are you sensitive or allergic to any drugs?  Penicillin;  Tetracycline;  Sulfa Drugs;  Other ..... Yes No  
If other, what drugs? \_\_\_\_\_
8. Do you have, or have you had any of the following: (Please check known conditions) ..... Yes No
 

<input type="checkbox"/> Anemia	<input type="checkbox"/> Blood Diseases	<input type="checkbox"/> Rheumatism or Arthritis	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Heart Ailments	<input type="checkbox"/> Hepatitis, Jaundice or Liver Disease	<input type="checkbox"/> Head Injuries	<input type="checkbox"/> Mental Disorders
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Stomach Ulcers	<input type="checkbox"/> Stroke
<input type="checkbox"/> Respiratory Disease	<input type="checkbox"/> Tumors or Growths	<input type="checkbox"/> Difficulty in Swallowing	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Radiation Treatment of any kind	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Herpes
<input type="checkbox"/> Nervous Disorders	<input type="checkbox"/> Allergies	<input type="checkbox"/> Acquired Immune Deficiency Syndrome	<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Asthma or Hay Fever	<input type="checkbox"/> Extreme Fatigue	<input type="checkbox"/> Cold Sores
<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Fainting Spells or Seizures	<input type="checkbox"/> Extreme Weight Loss	<input type="checkbox"/> Red or White Painful Sores in Mouth
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Artificial Prosthesis (Implants)	<input type="checkbox"/> Dry Mouth	<input type="checkbox"/> Other _____
<input type="checkbox"/> Headaches	<input type="checkbox"/> Night Sweats	<input type="checkbox"/> MVP	
<input type="checkbox"/> Light Sensitivity	<input type="checkbox"/> Diarrhea		
9. Do you wear a cardiac pacemaker ..... Yes No
10. Have you had heart surgery? ..... Yes No
11. Do you have any disease, condition or problem not listed that you think I should know about? ..... Yes No  
If so, what? \_\_\_\_\_
12. Have you had a joint replacement ..... Yes No
13. (Women) Are you pregnant? If so, how many months ..... Yes No

## DENTAL HISTORY

1. Have you ever had a local anesthetic (Novacaine, 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? \_\_\_\_\_
5. How long since your last Dental treatment? \_\_\_\_\_
6. Are you satisfied with the appearance of your teeth? ..... Yes No
7. Is it very important for you to keep your natural teeth? ..... Yes No
8. Reason for leaving previous Dentist \_\_\_\_\_
9. Does dental treatment make you nervous? ..... Yes No  
If Yes, Check :  Slightly  Moderate  Extremely
10. Would you desire to be pre-sedated or use Nitrous Oxide ..... Yes No

Date \_\_\_\_\_ Signature \_\_\_\_\_  
 Year 2  
 Change in Health \_\_\_\_\_  
 Date \_\_\_\_\_ Signature \_\_\_\_\_  
 Year 3

	Year 1	Year 2	Year 3
Date _____	_____	_____	_____
BP _____	_____	_____	_____
Pulse _____	_____	_____	_____

## CONSENT:

The undersigned hereby authorizes Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient) \_\_\_\_\_ and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered, (unless prior arrangements are made)

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

Relationship to Patient \_\_\_\_\_