YOUR NAME _____ DATE _____

HOW DID YOU FIND OUT ABOUT OUR OFFICE? PLEASE CHECK ONE:

☐ FRIEND OR FAMILY
☐ YELLOW PAGES
☐ RECEIVED AN ADVERTISING POST CARD/FLYER
☐ BILLBOARDS OR BUS BENCHES
☐ BUILDING SIGN
☐ MEDICAL REFERRAL
☐ TV COMMERCIALS
☐ OTHER _____
☐ REFERRED BY _____

PATIENT'S NAME _____
FIRST INITIAL LAST

PATIENT'S ADDRESS _____
STREET CITY STATE ZIP

SOC. SEC. NO. _____ HOME PHONE (____)_____ BUSINESS PHONE (____)_____

EMAIL ADDRESS _____ CELL PHONE (____)_____

☐ MALE ☐ FEMALE MARRIED? ☐ YES ☐ NO BIRTH DATE _____ AGE ____ ☐ MINOR IF MINOR, GIVE PARENT/GUARDIAN NAME _____ RELATIONSHIP)_____

DRIVER'S LICENSE NO. _____ EMPLOYED BY _____ OCCUPATION _____

EMPLOYER'S ADDRESS _____
STREET CITY STATE ZIP

SPOUSE'S NAME _____ DRIVER'S LIC. NO. _____ SOC. SEC. NO. _____

SPOUSE'S EMPLOYER _____ OCCUPATION _____ BUSINESS PHONE (____)_____

SPOUSE'S EMPLOYER'S ADDRESS _____
STREET CITY STATE ZIP

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU _____ RELATIONSHIP _____

RELATIVE'S ADDRESS _____ HOME PHONE (____)_____
STREET CITY STATE ZIP

PATIENT'S PHYSICIAN _____ BUSINESS PHONE (____)_____

PHYSICIAN'S ADDRESS _____
STREET CITY STATE ZIP

PATIENT'S FORMER DENTIST _____ BUSINESS PHONE (____)_____

FOMER DENTIST'S ADDRESS _____
STREET CITY STATE ZIP

DENTAL HISTORY

1. HAVE YOU EVER HAD A LOCAL ANESTHETIC (NOVOCAIN, 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 PREVIOUS DENTAL TREATMENT? ..... ☐ YES ☐ NO

   IF SO, PLEASE EXPLAIN _____
4. HOW LONG SINCE YOUR LAST FULL MOUTH X-RAYS? _____
5. HOW LONG SINCE YOUR LAST DENTAL TREATMENT? _____
6. DOES DENTAL TREATMENT MAKE YOU NERVOUS? ..... ☐ SLIGHTLY ☐ MODERATELY ☐ EXTREMELY ☐ NO
7. WOULD YOU DESIRE TO BE PRE-SEDATED? ..... ☐ YES ☐ NO

CONSENT FOR TREATMENT

THE HEALTH HISTORY I HAVE WRITTEN ON THE FRONT AND BACK OF THIS FORM IS COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE AND GIVE CONSENT TO PERFORM DENTAL SERVICES AGREED BETWEEN DOCTOR AND PATIENT AND/OR GUARDIAN TO BE NECESSARY OR ADVISABLE, INCLUDING THE USE OF LOCAL ANESTHESIA AND OTHER MEDICATIONS AS INDICATED. I AGREE THAT, REGARDLESS OF INSURANCE COVERAGE, I AM RESPONSIBLE FOR PAYMENT FOR SERVICES RENDERED AND THAT A FINANCE CHARGE OF 1 ½ % (ONE AND ONE HALF PERCENT) WILL BE APPLIED TO ACCOUNTS OVER SIXTY (60) DAYS PAST DUE.

_____ _____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE

MEDICAL HISTORY

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.

1. ARE YOU IN GOOD HEALTH? ..... ☐ YES ☐ NO
2. DATE OF LAST PHYSICAL EXAMINATION _____
3. ARE YOU 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? ☐ YES ☐ NO
   IF YES, WHICH DRUGS? ☐ PENICILLIN ☐ TETRACYCLINE ☐ SULFA DRUGS ☐ ASPIRIN ☐ CODEINE ☐ OTHER
   IF OTHER, WHAT DRUGS? _____
8. ARE YOU SENSITIVE TO LATEX? ..... ☐ YES ☐ NO
9. HAVE YOU EVER TAKEN PRESCRIPTION MEDICATION FOR WEIGHT LOSS (DIET PILLS)? ..... ☐ YES ☐ NO
   IF YES, DID YOU TAKE ANY OF THE FOLLOWING? FEN-PHEN (FENFLURAMINE-PHENPERMINE) ☐ YES ☐ NO
   PONDIMINE (FENFLURAMINE) ☐ YES ☐ NO
   RENDUX (DEXFENFLURAMINE) ☐ YES ☐ NO
10. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? (PLEASE CHECK "Yes" or "No"):

Yes	No		Yes	No		Yes	No	
☐	☐	ANEMIA	☐	☐	BRUISE EASILY	☐	☐	CEREBRAL PALSY
☐	☐	HERPES	☐	☐	HEAD INJURIES	☐	☐	BLOOD TRANSFUSION
☐	☐	STROKE	☐	☐	HEART FAILURE	☐	☐	JOINT REPLACEMENT
☐	☐	ULCERS	☐	☐	LIVER DISEASE	☐	☐	NERVOUS DISORDERS
☐	☐	DIABETES	☐	☐	SCARLET FEVER	☐	☐	TUMORS OR GROWTHS
☐	☐	GLAUCOMA	☐	☐	CHICKEN POX	☐	☐	ALLERGIES OR HIVES
☐	☐	ARTHRITIS	☐	☐	SINUS TROUBLE	☐	☐	EXCESSIVE BLEEDING
☐	☐	EMPHYSEMA	☐	☐	BLOOD DISEASE	☐	☐	ASTHMA
☐	☐	HAY FEVER	☐	☐	DRUG ADDICTION	☐	☐	HIGH BLOOD PRESSURE
☐	☐	TONSILLITIS	☐	☐	KIDNEY DISEASE	☐	☐	AIDS RELATED COMPLEX
☐	☐	COLD SORES	☐	☐	ANGINA PECTORIS	☐	☐	PAIN IN JAW JOINTS
☐	☐	HEMOPHILLIA	☐	☐	MENTAL DISORDER	☐	☐	RESPIRATORY DISEASE
☐	☐	RHEUMATISM	☐	☐	RHEUMATIC FEVER	☐	☐	SICKLE CELL DISEASE
☐	☐	HEART MURMUR	☐	☐	THYROID DISEASE	☐	☐	TUBERCULOSIS (TB)
☐	☐	EPILEPSY OR SEIZURES	☐	☐	ARTIFICIAL PROSTHESIS	☐	☐	PSYCHIATRIC TREATMENT
☐	☐	CONGENITAL HEART LESIONS	☐	☐	DIFFICULTY SWALLOWING	☐	☐	HEART AILMENTS OR ATTACK
☐	☐	X-RAY OR COBALT TREATMENT	☐	☐	FAINTING SPELLS OR SEIZURES	☐	☐	CHEMOTHERAPY (CANCER, LEUKEMIA)
☐	☐	RADIATION TREATMENT (ANY KIND)	☐	☐	HEPATITIS OR JAUNDICE	☐	☐	VENEREAL DISEASE
☐	☐	AIDS	☐	☐	LATEX ALLERGY	☐	☐	OTHER _____

11. DO YOU WEAR A CARDIAC PACEMAKER, OR HAVE YOU HAD HEART SURGERY? ..... ☐ YES ☐ NO
12. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED THAT WE SHOULD KNOW ABOUT? ..... ☐ YES ☐ NO
    IF SO, WHAT? _____
13. (WOMAN) ARE YOU PREGNANT? ☐ YES ☐ NO IF SO, HOW MANY MONTHS? _____
14. (WOMAN) DO YOU HAVE ANY PROBLEMS ASSOCIATED WITH YOUR MENSTRUAL PERIOD? ..... ☐ YES ☐ NO
15. (WOMAN) DO YOU TAKE BIRTH CONTROL PILLS? ..... ☐ 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.

SIGNATURE: _____ DATE: _____

YEAR 2:
CHANGES IN HEALTH: _____
SIGNATURE: _____ DATE: _____

YEAR 3:
CHANGES IN HEALTH: _____
SIGNATURE: _____ DATE: _____

YEAR 4:
CHANGES IN HEALTH: _____
SIGNATURE: _____ DATE: _____

HEALTH QUESTIONNAIRE MUST BE UPDATED EACH YEAR

DO NOT WRITE IN THIS SPACE – FOR OFFICE USE ONLY

REVIEWED BY		**YEAR 1**	**YEAR 2**	**YEAR 3**	**YEAR 4**
INITIALS: _____ YEAR 1	DATE				
INITIALS: _____ YEAR 2	BP				
INITIALS: _____ YEAR 3	PULSE				
INITIALS: _____ YEAR 4	TEMP				

FINANCIAL INFORMATION

1. DO YOU HAVE DENTAL INSURANCE? ☐YES ☐NO
   NAME OF INSURANCE COMPANY _____
   ADDRESS OF INSURANCE COMPANY _____
   POLICY NO. _____ LOCAL NO. _____ BIRTH DATE _____
   NAME OF INSURED _____ INSURED'S SOC. SEC. NO. _____

2. DO YOU HAVE A DENTAL INSURANCE PLAN? ☐YES ☐NO
   NAME OF INSURANCE COMPANY _____
   ADDRESS OF INSURANCE COMPANY _____
   POLICY NO. _____ LOCAL NO. _____ BIRTH DATE _____
   NAME OF INSURED _____ INSURED'S SOC. SEC. NO. _____

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