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. ____________