WELCOME TO OUR OFFICE

We are a health centered dental practice. Thus, we are concerned with your total well-being, not just your oral health. An essential part of our approach is a thorough health history. Please fill out the health questionnaire below completely-even if some of the questions may not seem relevant to your dental health. Thank You!

What are your hobbies or special interests? _____

Do you have or ever had any of the following? *(Please circle Y or N as applicable) also circle the appropriate health condition.*

Hypoglycemia, Diabetes	Y / N	Prosthetic Valves, Joints, or Implants	Y / N
Heart Attack or Heart Trouble	Y / N	Stroke	Y / N
Hay Fever, Asthma, Allergies	Y / N	Heart Murmur, Mitral Valve Prolapse	Y / N
High Blood Pressure	Y / N	Rheumatic Fever	Y / N
Circulatory Problems	Y / N	Anemia, Blood Disorder	Y / N
Hepatitis, Jaundice	Y / N	Excessive Bleeding	Y / N
Lung Problems, Tuberculosis	Y / N	Fainting, Blackouts	Y / N
Epilepsy, Seizures	Y / N	Nervous Disorders	Y / N
Blood Transfusions	Y / N	Headaches, Migraines	Y / N
Facial or Head Injuries	Y / N	Kidney Problems	Y / N
Radiation, Chemotherapy	Y / N	Glaucoma, Eye Problems	Y / N
Malignancies, Cancer	Y / N	Ulcers, Digestive Problems	Y / N
Sinus Problems	Y / N	History of Eating Disorders	Y / N
AIDS, ARC	Y / N	Are you pregnant now?	Y / N
HIV Positive	Y / N	Other _____	
Arthritis or Rheumatism	Y / N		

Name, phone of physician_____ Date of last physical _____/_____/_____

Do you need a referral for a physician or specialist? Y / N

Have you been hospitalized in the last two years? Y / N If yes, please explain _____

_____

Have you had unfavorable reactions to any of the following? (Please circle)

Aspirin Codeine Anesthetics Xylocaine Novocaine Sedatives Penicillin Erythromycin Other antibiotics

Metals (jewelry) Latex Other drugs _____

Please list any drugs currently being taken _____

Reason for this dental visit _____

Date of last dental visit _____ What was done at that time? _____

Have you ever been treated by a periodontist, orthodontist, or endodontist? Y / N If yes, please explain _____

_____ Date of last x-rays _____/_____/_____

Are you happy with the appearance of your teeth? Y / N

Have you noticed any of the following?		Recurring sore in or around the mouth	Y / N
Teeth tender when chewing	Y / N	Jaw clicking or popping	Y / N
Discomfort in face, head, neck, jaw	Y / N	Loose teeth	Y / N
Food caught between teeth	Y / N	Swelling, lumps in mouth	Y / N
Bleeding or sore gums	Y / N	Do you need gas, oral or IV sedation for dental	
Sensitivity to sweets, hot or cold	Y / N	visits?	Y / N

Have you had any problems with previous dental treatment? Y / N If so, please explain. _____

_____

The information above is correct to the best of my knowledge.

Signature _____ **Date** _____

***FOR OFFICE USE ONLY:** Medical history updated_____/_____/_____/_____/_____

(Please complete both sides)

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(Please be complete in your answers. We respect total confidentiality.)

PERSONAL INFORMATION

Mr./Mrs./Ms/Miss _____
First *Middle Initial* *Last*

What name shall we call you? _____ Date of birth ____/____/____ Home phone (____)_____ - _____

Cell phone (____)_____ - _____

Home address_____ City_____ State_____ Zip_____

Billing address_____ City_____ State_____ Zip_____

Driver license #_____ State_____ Social Security #_____-_____-_____

Employer_____ Occupation _____Work phone (____)_____-_____

Spouse name _____Spouse work phone (____)_____-_____

Spouse SS#_____ Spouse Cell # _____ Spouse date of birth _____

Parent or Guardian name if patient is a minor _____

Person to contact in emergency _____ Relation_____Phone (____)_____-_____

Do you have dental insurance?_____ Policy # _____ Group # _____

Subcriber name _____ Subscriber date of birth _____

Subscriber SS# _____

Name of Dental Ins. Co._____ Phone # (_____)_____-_____

WHO MAY WE THANK FOR REFERRING YOU TO US? _____

To avoid any misunderstandings regarding your dental insurance, we wish our patients to know that all **professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees.** We do not render services on the basis that the insurance companies will pay our fees unless a pre-determination of benefits has been established. We will file your insurance claims as a service to you. **Payment is due when services are rendered unless other arrangements have been made.** If you must change a scheduled appointment, please inform us as soon as possible. Failed appointments and last minute cancellations affect many people. **Please notify us by 3:00 p.m. the working day prior to the day of your appointment if you can not keep your scheduled appointment.** This allows someone else to take your appointment time.

I hereby authorize Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of my dental needs. I also authorize Doctor to prescribe any and all forms of medication, and perform any therapy that may be indicated and agreed upon. I further authorize the release of any information, including the diagnosis and the records of any treatments or examinations rendered, to my insurance company or consulting professionals. The release to the insurance company is solely for the purpose of facilitating the billing and reimbursement directly to the dentist of insurance benefits under which I am entitled. I understand that responsibility for payment for dental services provided in this office for me or my dependants is mine, due and payable at the time services are rendered.

Signature of patient or responsible party _____ **date**_____

(please complete both sides)

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