# HEALTH QUESTIONNAIRE

| | Blood Pressure | Date |
|---|---|---|
| Year 1 | | |
| Year 2 | | |
| Year 3 | | |

| Insurance | | |
|---|---|---|
| Name | Date of Birth | Acct # |

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 concern, but they are all associated with proper oral health care. Please answer each question and mark YES or NO as appropriate

## MEDICAL HISTORY

| | Yes | No |
|---|---|---|
| 1. Are you in good health? | ❑ | ❑ |
| 2. Are you now under the care of a physician? | ❑ | ❑ |
| If so, what is the condition being treated? _____ | | |
| Physician name / phone # / address _____ | | |
| 3. Have you ever had any serious illness or operation? | ❑ | ❑ |
| If so, what illness or operation? _____ | | |
| 4. Have you ever been hospitalized? | ❑ | ❑ |
| If so, what was the problem? _____ | | |
| 5. Are you taking medicine? ❑ Yes ❑ No or any recreational drugs (marijuana, cocaine, etc.) | ❑ | ❑ |
| If so, what? _____ What dosage? _____ | | |
| 6. Are you sensitive or allergic to any drugs? ❑ Penicillin ❑ Tetracycline ❑ Sulfa Drugs ❑ Aspirin ❑ Codeine | ❑ | ❑ |
| Other: If other, what drug(s)? _____ | | |

7. Do you have, or have you had, any of the following:

| Yes | No | | Yes | No | | Yes | No | | Yes | No | | Yes | No | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ❑ | ❑ | Heart Murmur | ❑ | ❑ | Joint Replacement | ❑ | ❑ | Epilepsy or Seizures | ❑ | ❑ | Anemia | ❑ | ❑ | Liver Disease |
| ❑ | ❑ | High Blood Pressure | ❑ | ❑ | Allergies or Hives | ❑ | ❑ | Heart Ailments or Attack | ❑ | ❑ | Ulcers | ❑ | ❑ | Sinus Trouble |
| ❑ | ❑ | Radiation Therapy | ❑ | ❑ | Cortisone Medicine | ❑ | ❑ | Hepatitis or Jaundice | ❑ | ❑ | Glaucoma | ❑ | ❑ | Blood Disease |
| ❑ | ❑ | Rheumatic Fever | ❑ | ❑ | Excessive Bleeding | ❑ | ❑ | Fainting Spells or Seizures | ❑ | ❑ | Arthritis | ❑ | ❑ | Drug Addiction |
| ❑ | ❑ | Tuberculosis (T.B.) | ❑ | ❑ | Latex Allergy | ❑ | ❑ | Chemotherapy (Cancer, Leukemia) | ❑ | ❑ | Emphysema | ❑ | ❑ | Kidney Disease |
| ❑ | ❑ | Cardiac Pacemaker | ❑ | ❑ | Pain in Jaw Joints | ❑ | ❑ | Venereal Disease (Syphilis, Gonorrhea) | ❑ | ❑ | Cold Sores | ❑ | ❑ | H.I.V./AIDS |
| ❑ | ❑ | Nervous Disorders | ❑ | ❑ | Respiratory Disease | ❑ | ❑ | Artificial Prosthesis | ❑ | ❑ | Bruise Easily | ❑ | ❑ | Asthma |
| ❑ | ❑ | Thyroid Disease | ❑ | ❑ | Mental Disorder | ❑ | ❑ | Angina Pectoris | ❑ | ❑ | Head Injuries | ❑ | ❑ | Hemophilia |
| ❑ | ❑ | Tumors or Growths | ❑ | ❑ | Psychiatric Treatment | ❑ | ❑ | Congenital Heart Lesions | ❑ | ❑ | Diabetes | ❑ | ❑ | Stroke |
| ❑ | ❑ | Blood Transfusion | ❑ | ❑ | Cerebral Palsy | ❑ | ❑ | Heart Surgery (Valve Replacement) | ❑ | ❑ | Prosthetic Joints | | | |

| | Yes | No |
|---|---|---|
| 8. Do you have any disease, condition or problem not listed that you think we should know about? | ❑ | ❑ |
| If so, what? _____ | | |
| 9. Do you smoke? If yes, how much per day? | ❑ | ❑ |
| 10. Are you currently taking, or have you ever taken the drug Phen-Phen? | ❑ | ❑ |
| 11. (**Women**) Is there a possibility you may be pregnant? | ❑ | ❑ |
| 12. (**Women**) Do you have any problems associated with your menstrual period? | ❑ | ❑ |
| 13. (**Women**) Do you take birth control pills?. | ❑ | ❑ |

## DENTAL HISTORY

| | | | |
|---|---|---|---|
| 1. Have you ever had a local anesthetic (Novocaine, etc.)? | | | ❑ ❑ |
| 2. Have you ever had any unfavorable reaction from a local anesthetic? | | | ❑ ❑ |
| 3. Have you had any serious trouble associated with any previous dental treatment? | | | ❑ ❑ |
| If so, explain _____ | | | |
| 4. How long since your last full mouth x-rays? _____ | | | |
| 5. How long since your last dental treatment? _____ | | | |
| 6. Is any current dental problem the result of an accident? | ❑ YES | ❑ NO | WHEN? _____ |
| 7. Does dental treatment make you nervous? | ❑ No | ❑ Slightly | ❑ Moderately ❑ Extremely |

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.

Patient Signature: _____ Date: _____ DDS Signature: _____ Date: _____

Year 2: Change in Health: _____ ❑ None

Patient Signature _____ Date: _____ DDS Signature: _____ Date: _____

Year 3: Change in Health: _____ ❑ None

Patient Signature: _____ Date: _____ DDS Signature: _____ Date: _____

## DDS NOTES

_____

_____

_____

# CONFIDENTIAL PATIENT INFORMATION

## PATIENT HISTORY INFORMATION

PATIENT'S NAME _____ HOME PHONE _____
SOC. SEC. # _____ BIRTHDATE _____ AGE _____ SEX _____ MARITAL STATUS _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
PATIENT'S EMPLOYER _____ WORK PHONE _____
SPOUSE'S NAME _____ SPOUSE'S EMPLOYER _____
PERSON TO NOTIFY IN CASE OF EMERGENCY _____ PHONE _____
RELATIVE OR FRIEND NOT LIVING WITH YOU _____ PHONE _____
STUDENT: ❒ FULL TIME ❒ PART TIME SCHOOL _____ CITY _____

| FAMILY MEMBERS: | | AGE | | AGE |
|---|---|---|---|---|
| SPOUSE | | | CHILD | |
| CHILD | | | CHILD | |
| CHILD | | | CHILD | |

## RESPONSIBLE PARTY'S INFORMATION

PERSON RESPONSIBLE FOR ACCOUNT _____
RELATIONSHIP TO PATIENT _____ HOME PHONE _____ WORK PHONE _____
MAILING ADDRESS _____ CITY _____ ZIP _____
SOC. SEC. # _____ DRIVER'S LICENSE # _____
EMPLOYER _____ OCCUPATION _____
EMPLOYER'S ADDRESS _____ CITY _____ ZIP _____

DENTAL INSURANCE ❒ YES ❒ NO
INSURED'S NAME _____
SS # _____ BIRTHDAY _____
EMPLOYER _____
INS. CO. OR PLAN _____
UNION/GRP. NAME _____
GRP. OR POLICY # _____ LOCAL # _____
DATE EMPLOYED _____

SECONDARY INSURANCE ❒ YES ❒ NO
INSURED'S NAME _____
SS # _____ BIRTHDAY _____
EMPLOYER _____
INS. CO. OR PLAN _____
UNION/GRP. NAME _____
GRP. OR POLICY # _____ LOCAL # _____
DATE EMPLOYED _____

HOW DID YOU HEAR ABOUT THIS OFFICE? ❒ FORMER PATIENT WHO? _____
❒ UNION ❒ TELEPHONE BOOK ❒ SAW BLDG./SIGN ❒ EMPLOYER
❒ ADVERTISEMENT WHICH? _____ ❒ OTHER _____
WHY ARE YOU HERE TODAY? ❒ CHECK-UP ❒ TOOTHACHE ❒ BRACES ❒ CAPS ❒ IMPROVE SMILE
❒ OTHER _____

## CONSENT TO FINANCIAL RESPONSIBILITY

This is to certify that I, the undersigned, consent to the performing of whatever dental services and/or surgical procedures may be decided upon to be necessary or advisable, and to the use of local or general anesthetic as may be deemed advisable by the dentist. I have also explained the consequences of partial and/or no treatment. I hereby authorize my dentist to release any and all medical information (including dental information) to the above-named insurance carrier for purpose of claims administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from the date of signing until revoked in writing.

I hereby authorize my Insurance Carrier to pay directly to the within named dentist(s) the dental benefits otherwise payable to me. I understand if my insurace company does not pay in full, I am responsible for the remaining balance. I understand some dental services I receive may require a co-payment from me. The amount of co-payment will vary according to the insurance/dental plan I have and the procedure that is performed. If my insurance/dental plan has a yearly deductible, I understand it must be satisfied before treatment begins. I also understand co-payments must be paid in full at the time of treatment. A finance charge of 1.5% per month (18% per annum) will be charged onthe unpaid principal balance on all accounts not paid within 30 days of the date of service.

I further understand dental services not covered by my insurance/dental plan may be prescribed in certain cases by the attending dentists. Usual, customary and reasonable fees will be charged for such services.

I also understand there will be a charge for any missed appointment which is not cancelled 24 hours in advance.

## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby acknowledge that I have received a copy of this office's notice of privacy practices. I have been given the opportunity to ask questions I may have regarding this notice. I understand that by signing this consent form I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

_____ _____
Patient Signature or Responsible Party Date