PATIENT INFORMATION AND HEALTH QUESTIONNAIRE

PLEASE ANSWER THE FOLLOWING QUESTIONS IN DETAIL. ALL INFORMATION WILL BE CONSIDERED CONFIDENTIAL AND FOR OUR RECORDS ONLY. DRUGS INCLUDING ALCOHOL OR HORMONES MAY INFLUENCE THE MANAGEMENT OF YOUR DENTAL TREATMENT.

NAME_____ DATE OF BIRTH_____

ADDRESS_____ POSTAL CODE_____

PHONE: HOME_____ WORK_____ CELL_____

EMAIL_____ PHYSICIAN'S NAME _____

INSURANCE COMPANY_____ POLICY #_____ ID #_____

CONTACT PERSON_____ RELATIONSHIP_____ PHONE_____

MEDICAL HISTORY

DATE OF LAST MEDICAL CHECK UP_____

ARE YOU CURRENTLY UNDER A PHYSICIAN'S CARE? YES / NO REASON_____

HAVE YOU HAD A SERIOUS ILLNESS, OPERATION, OR BEEN HOSPITALIZED? YES / NO
PLEASE SPECIFY_____

ARE YOU PRESENTLY TAKING ANY MEDICATIONS, EITHER PRESCRIBED OR SELF-ADMINISTERED? (E.G. SUPPLEMENTS) YES / NO
PLEASE LIST_____

DO YOU HAVE ANY CIRCULATION PROBLEMS OF ANY KIND?_____

DO YOU HAVE ANY HEART CONDITIONS, MURMURS, OR BLOOD PRESSURE PROBLEMS (HIGH/LOW)? YES / NO _____

DO YOU HAVE AN ARTIFICIAL JOINT OF ANY KIND? YES / NO_____ PLACEMENT DATE:_____

DO YOU HAVE ANY ALLERGIES? YES / NO _____

ARE YOU SUBJECT TO PROLONGED BLEEDING? YES / NO _____

DO YOU BRUISE EASILY? YES / NO _____

DO YOU HAVE ANY IMMUNE DISORDERS? YES / NO _____

HAVE YOU HAD ANY REACTIONS TO MEDICATIONS? YES / NO PLEASE SPECIFY _____

HAVE YOU EVER TAKEN PENICILLIN? YES / NO ANY ADVERSE REACTIONS? _____

HAVE YOU EVER FAINTED? YES / NO _____

DO YOU SMOKE OR CHEW TABACCO PRODUCTS? YES / NO HOW LONG?_____ HOW MUCH?_____

WOMEN: ARE YOU PREGNANT OR BREASTFEEDING? YES / NO DUE DATE _____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS?

	Yes	No		Yes	No		Yes	No
ANEMIA	( )	( )	HEART ATTACK	( )	( )	RHEUMATISM	( )	( )
ARTHRITIS	( )	( )	HEPATITIS	( )	( )	SCARLET FEVER	( )	( )
ASTHMA	( )	( )	KIDNEY DISEASE	( )	( )	SEIZURES / EPILEPSY	( )	( )
BLOOD DISORDER	( )	( )	LIVER DISEASE	( )	( )	SHORTNESS OF BREATH	( )	( )
CANCER	( )	( )	LUNG DISEASE	( )	( )	STEROID THERAPY	( )	( )
CATARACTS	( )	( )	NERVOUS DISORDER	( )	( )	STROKE	( )	( )
CHEST PAIN / ANGINA	( )	( )	PACEMAKER	( )	( )	STOMACH ULCER	( )	( )
DIABETES	( )	( )	PROSTHETIC HEART VALVE	( )	( )	THYROID DISEASE	( )	( )
DRUG/ALCOHOL DEPENDENCY	( )	( )	RHEUMATIC FEVER	( )	( )	TUBERCULOSIS	( )	( )

OTHER_____

PATIENT (PARENT) SIGNATURE _____ DATE _____

MEDIC ALERT: THIS BOX FOR OFFICE USE ONLY. DO NOT FILL OUT.

INFORMED CONSENT AND GENERAL RELEASE

I, the undersigned, declare that I have read, understood, asked and received an answer or explanation for any reason I did not understand and have answered all the dental / medical questions accurately.

A) I consent to my physician Dr.______________________________ Phone______________________________ being contacted if necessary.

B) I authorize the dentist to perform all diagnostic, dental and oral surgery procedures and services including the use of local anesthetics as may be necessary.

C) I understand and agree that I am obligated to accept responsibility for payment of all dental services provided to me and / or my dependents. A 2% interest charge will be applied to all accounts outstanding over 60 days.

Patient or Parent / Guardian Signature____

If Parent or Guardian
please print name______________________________ Date ______________________
(Guardian of child or of an adult under Guardianship)

Reviewing Dentist ______________________________ Date ______________________

MEDICAL HISTORY UPDATE

IF CHANGED, RECORD IN MEDICAL HISTORY

DATE	SAME	CHANGE	PATIENT/PARENT/GUARDIAN SIGNATURE	DR INITIALS
________	( )	( )	______________________________	________
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