INFORMATION AND HEALTH QUESTIONNAIRE

To help ensure your well being while undergoing treatment in our office, please answer the following questions in detail. Naturally, all information will be considered confidential and for our records only.

Name _____ Date of Birth (D/M/Y) _____

Home Address _____

Postal Code _____ Phone _____

Previous Dentist and Address _____

Length of time with previous dentist _____

Physician's Name and Address _____

Phone _____

What is your estimate of your general health?

Good Fair Poor

	YES	NO
Have you ever had any serious illness or operation?	☐	☐
Have you ever been hospitalized?	☐	☐
Do you have or have you had any of the following diseases or problems?		
Rheumatic fever or rheumatic heart disease	☐	☐
Congenital heart defect	☐	☐
Cardiovascular disease (heart trouble, heart attack, coronary occlusion, Coronary insufficiency, high blood pressure, arteriosclerosis, Stroke)	☐	☐
Do you have pain in the chest upon exertion?	☐	☐
Are you short of breath after mild exercise?	☐	☐
Do your ankles swell?	☐	☐
Do you get short of breath when you lie down?	☐	☐
Do you require extra pillows during sleep?	☐	☐
Allergy	☐	☐
Asthma or hay fever	☐	☐
Hives or skin rash	☐	☐
Fainting spells, seizures, or epilepsy	☐	☐
Arthritis	☐	☐
Stomach ulcers	☐	☐
Diabetes	☐	☐
Do you urinate (pass water) more than 6 times a day?	☐	☐
Are you thirsty much of the time?	☐	☐
Does your mouth frequently become dry?	☐	☐
Hepatitis, jaundice, or liver trouble	☐	☐
Kidney trouble	☐	☐
Venereal disease, A.I.D.S	☐	☐
Tuberculosis or other respiratory disease	☐	☐
Thyroid disorder	☐	☐
Cancer	☐	☐
Sinus trouble	☐	☐
Do you have any blood disorder such as anemia?	☐	☐
Have you ever experienced numbness or tingling in any part of your Body?	☐	☐
Have you ever had abnormal bleeding after previous extractions, surgery, or trauma?	☐	☐
Do you bruise easily?	☐	☐

	YES	NO
Have you ever been troubled by frequent nose bleeds?.....	☐	☐
Have you ever required a blood transfusion?.....	☐	☐

Are you allergic or have you reacted adversely to:

…..Local anesthetics ("Novocain")
…..Penicillin or other antibiotics
…..Barbiturates, sedatives or sleeping pills?
…..Sulpha drugs
…..Aspirin
…..Other

What medications are you currently taking?

.....
.....
.....

Do you wear contact lenses?.....	☐	☐
Are you following a special diet?.....	☐	☐
Has your weight changed by more than 10 pounds in the past 6-12 months?.....	☐	☐
Do you smoke? If so, how much?.....	☐	☐
Do you suffer from frequent headaches or spells of dizziness?.....	☐	☐
Are you under tension (e.g. business, social, marital)?.....	☐	☐
Are you easily upset, irritated, or depressed?.....	☐	☐
Have you ever had any serious trouble associated with any previous dental experience?.....	☐	☐
Do you have any disease, condition, or problem, not listed previously that you feel we should know about?.....	☐	☐

WOMEN

Are you taking contraceptives or other hormones?.....	☐	☐
Are you pregnant?.....	☐	☐
If so, expected delivery date:_____		
Have you reached menopause?.....	☐	☐

POLICY OF THE OFFICE APPOINTMENTS

Please help us maintain the operation of our office on sound principles so that we may assure you and other patients of uninterrupted treatment. Remember that once you have made an appointment this time is reserved for you; therefore at least 48 HOURS NOTICE must be given if cancellation is absolutely necessary, to allow us time to schedule another patient waiting for treatment.

Informed Consent and General Release:

I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical-dental history. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I also understand that consultation with my medical doctor may be required, and I consent to my physician being contacted if necessary. I understand that responsibility for payment for the dental service provided for me or my dependents and I will assume responsibility for fees associated with these services.

I consent to the collection, use, retention and disclosure of personal information as is required for my own and my dependents dental care.

…… ……..

Signature of Patient (Parent/Guardian) *Date*

DATE	UPDATES