WELCOME TO OUR OFFICE

LAST NAME	FIRST	INITIAL	DATE OF BIRTH Y /M /D
MAILING ADDRESS			
CITY / PROVINCE			POSTAL CODE
TELEPHONE RESIDENCE	BUSINESS	MESSAGE	
OCCUPATION	EMPLOYER		
WHOM MAY WE THANK FOR REFERRING YOU?	EMERGENCY CONTACT NAME		NUMBER
PERSON RESPONSIBLE FOR ACCOUNT	DRIVERS LICENSE NO.	DO YOU HAVE DENTAL INSURANCE? ◯ YES ◯ NO	

PRIMARY DENTAL INSURANCE		SECONDARY DENTAL INSURANCE	
NAME OF INSURED	DATE OF BIRTH Y /M /D	NAME OF INSURED	DATE OF BIRTH Y /M /D
EMPLOYER		EMPLOYER	
INSURANCE CARRIER		INSURANCE CARRIER	
GROUP / POLICY NUMBER	DIVISION	GROUP / POLICY NUMBER	DIVISION
ID. / CERTIFICATE / MEMBER NUMBER		ID. / CERTIFICATE / MEMBER NUMBER	
COVERAGE PERCENTAGE A B C D		COVERAGE PERCENTAGE A B C D	
LIMITS / MAXIMUMS BASIC MAJOR ORTHO		LIMITS / MAXIMUMS BASIC MAJOR ORTHO	
DEDUCTIBLE BASIC MAJOR	◯ PER PERSON ◯ PER FAMILY	DEDUCTIBLE BASIC MAJOR	◯ PER PERSON ◯ PER FAMILY

HEALTH QUESTIONNAIRE

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

General — Please Circle

1. Have you been examined and / or treated by a physician within the last year? _____ ◯ Yes ◉ No
   Physician's Name _____ Physician's Phone _____
2. Have you ever been seriously ill or hospitalized? _____ ◉ Yes ◯ No
3. Have you ever experienced abnormal bleeding associated with previous extraction, surgery or trauma? ◉ Yes ◯ No
4. Are you taking any medications or non-prescription drugs now? _____ ◯ Yes ◯ No
   What? _____

Please check (√) if you have or have had any of the following:

SPECIFIC
- □ Rheumatic fever
- □ Heart murmur
- □ Congenital heart condition
- □ Heart attack
- □ Arteriosclerosis
- □ Stroke
- □ Angina pectoris
- □ Blood pressure problems
- □ Heart trouble
- □ Lung / breathing problems
- □ Kidney / bladder problems
- □ Stomach / intestinal problems
- □ Hepatitis / jaundice
- □ Liver disease
- □ Diabetes
- □ Blood disorders
- □ Pacemaker / artificial valves
- □ Artificial joints / implants
- □ Infectious / communicable disease
- □ Venereal disease
- □ AIDS
- □ Positive testing for HIV virus
- □ Tumors or growths
- □ Nervous / Mental problems
- □ Epilepsy
- □ Thyroid disease
- □ Arthritis
- □ Inflammatory rheumatism
- □ Cortisone / steroid therapy

SENSITIVITIES / ALLERGIES
- □ Hives / skin rash
- □ Asthma
- □ Hay Fever
- □ Allergies _____
- □ Unusual reaction to any drug

SYSTEMS REVIEW
- □ Prolonged bleeding after surgery
- □ Bruise easily
- □ High risk group for AIDS
- □ Severe headaches
- □ Sinus trouble
- □ Sore throats
- □ Earaches
- □ Trouble hearing
- □ Shortness of breath
- □ Chest pains
- □ Swollen ankles
- □ Heart palpitations
- □ Extra pillows for sleep
- □ Persistent cough
- □ Blood in sputum
- □ Recent change of appetite
- □ Foods that you cannot eat
- □ Difficulty in swallowing
- □ Frequent indigestion / vomiting
- □ Feel thristy much of the time
- □ Urinate more than 6 times / day
- □ Painful, swollen joints
- □ Numb / prickling sensations
- □ History of broken bones
- □ Tendancy to faint
- □ Fits, seizures or convulsions
- □ History of family disease

HABITS
- □ Tobacco
- □ Alcoholic beverages
- □ Non-prescription drugs
- □ Other

WOMEN ONLY: Are you
- □ Pregnant (how many months _____)
- □ Past menopause

Is there anything else concerning your health that you think the doctor should know about? ◯ Yes ◯ No

_____

Date_____ Signature_____ □ Patient □ Parent □ Guardian

NOTES:_____

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