Health Questionnaire

Your general health constitutes an important factor and in combination with other causes, may influence the course of periodontal disease. For your welfare and to assist in establishing a thorough diagnosis for successful treatment, please complete this confidential form.

MEDICAL HISTORY

1. Are you in good health? . . . . . Yes No
2. Date of last physical examination . . . . . .
3. Are you now under the care of a physician? . . . . . Yes No
   If so, what is the condition being treated? . . . . . .
4. Have you ever had excessive bleeding requiring special treatment? . . . . . Yes No
   If so, what for? . . . . . .
5. Have you ever been hospitalized? . . . . . Yes No
   If so, what was the problem? . . . . . .
6. Are you taking any drugs or medicine? . . . . . Yes No
   If so, what? . . . . . .
7. Are you sensitive or allergic to any drugs? ☐ Penicillin: ☐ Tetracycline ☐ Sulfa Drugs. . . . . Yes No
   If so, what drugs? . . . . . .Have you ever taken Phen-Fen? . . . . . Yes No
8. **Do you have, or have you had any of the following**: (PLEASE CIRCLE YES OR NO) . . . . . .

Y/N Anemia	Y/N High Blood Pressure	Y/N Radiation Treatment	Y/N Asthma or Hay Fever	Y/N Bone sparing drugs?
Y/N Blood Diseases	Y/N Kidney Disease	of any kind	Y/N Stroke	(i.e FOSAMAX)
Y/N Rheumatism or Arthritis	Y/N Stomach Ulcers	Y/N Epilepsy	Y/N Excessive Bleeding	Y/N Chemotherapy
Y/N Heart Ailments	Y/N Respiratory Disease	Y/N Nervous Disorders	Y/N Fainting Spells or Seizures	Y/N Current or previous
Y/N Hepatitis, Jaundice	Y/N Tumors or Growth	Y/N Allergies	Y/N Glaucoma	smoker?
or Liver Disease	Y/N Venereal Disease	Y/N Mental Disorders	Y/N Rheumatic Fever	Y/N Bisphosphonate use?
Y/N Head Injuries	Y/N Tuberculosis	Y/N Diabetes	Y/N Sinus Trouble	
Y/N Heart Murmur		Y/N HIV Positive	Y/N Other _____	Y/N LATEX ALLERGY?

9. Do you wear a cardiac pacemaker? . . . . . Yes No
10. Have you had heart surgery? . . . . . Yes No
11. Do you have any disease, condition or problem not listed above that you think I should know about? . . . . . Yes No
    If so, explain . . . . . .
12. (Women) Are you pregnant? If so, how many months? . . . . . Yes No
13. (Women) Do you have any problems associated with your menstrual period? . . . . . Yes No

DENTAL HISTORY

14. Do you breathe primarily through your mouth? . . . . . Yes No
15. Do you have frequent blisters on your lips or mouth? . . . . . Yes No
16. Do your gums bleed? . . . . . Yes No
17. Are you aware of a bad taste or odor in your mouth? . . . . . Yes No
18. Are you troubled with recurring gum boils or abscesses? . . . . . Yes No
19. Does your jaw ever get "out of joint" or "click"? . . . . . Yes No
20. Do you clench or grind your teeth? . . . . . Which? . . . . . Yes No
21. Have you ever had periodontal treatment? . . . . . When? . . . . . Yes No
22. Have you ever had orthodontic treatment? . . . . . When? . . . . . Yes No
23. Have you ever had any unfavorable reaction from local anesthetic (Novocaine, etc.)? . . . . . Yes No
24. Have you ever had any serious trouble associated with any previous dental treatment? . . . . . Yes No
    If so, explain . . . . . .
25. Does dental treatment make you nervous? . . . . . Yes No

Health History is Correct to the best of My Knowledge

Date. . . /. . . ./ . . . . Signature. . . . . .Date. . . /. . . ./ . . . . .Signature. . . . . .

Date. . . /. . . ./ . . . . .Signature. . . . . Date. . . /. . . ./ . . . . .Signature. . . . . .

Patient Information

(This information is necessary for our files and your health and will be considered CONFIDENTIAL)

Patient's Name . . . . . Age . . . . . Your date of birth . . . . . .

Residence Address . . . . . City . . . . . Zip . . . . . .

Home Phone # ( ). . . . . **. Cell Phone #** ( ). . . . . **SS #**: . . . . . .

E-MAIL ADDRESS. . . . . .

☐ Married ☐ Single ☐ Separated ☐ Widowed Spouse's Name . . . . . .

Employed by . . . . . Occupation . . . . . .

Business Address . . . . . Bus. Phone . . . . . .

Spouse Employed by . . . . . Occupation . . . . . .

Business Address . . . . . Bus. Phone . . . . . .

Name of nearest relative not living with you . . . . . Relationship . . . . . .

Complete Address . . . . . Res. Phone . . . . . .

Name of Physician. . . . . Address. . . . . Phone . . . . . .

Specialty . . . . . .

Name of Dentist . . . . . Address. . . . . Phone . . . . . .

How Long? . . . . . .

Purpose of Appointment. . . . . .

Referred by . . . . . .

FINANCIAL INFORMATION (ALSO NECESSARY FOR INSURANCE PROCESSING)

Person responsible for this account. . . . . Relationship . . . . . .

RESPONSIBLE PERSON'S SS#.....AND BIRTH DATE. . . . . .

Address. . . . . Phone . . . . . .

Dental Insurance (Name of Co.) (Primary) . . . .

Insurance Group No. . . . . .

.Soc. Sec. No. of Insured . . . . . .

Dental Insurance (Name of Co.) (Secondary).. . . . . . .

Insurance Group No. . . . . .

Soc. Sec. No. of Insured . . . . . .

INSURANCE

To avoid misunderstanding regarding dental insurance, we wish our patients to know that **ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED DIRECTLY TO THE PATIENT and the PATIENTS ARE PERSONALLY RESPONSIBLE FOR PAYMENT OF FEES.** We will prepare necessary forms or reports to help you to obtain your benefits from insurance companies. We do not render our services on the basis that insurance companies will pay all our fees. Patients will be responsible for any cost incurred in collection of a delinquent account. Each fee is individual for the individual patient.

APPOINTMENTS

So that we may assure you and other patients of uninterrupted treatment, it is necessary for all patients to accept and adhere to a definite arrangement of appointments and fees. Once an appointment is made, please remember this time is reserved for you; **AT LEAST 24 HOURS NOTICE MUST BE GIVEN IF CANCELLATION IS ABSOLUTELY NECESSARY, OTHERWISE CANCELLATION CHARGE MAY BE MADE.**

CONSENT FOR EXAMINATION: I hereby grant authority to Dr. Schultz to examine and perform such diagnostic procedures (including radiographs) as he deems necessary or advisable and **to share these findings with my referring doctor(s) and insurance companies (to process my claim(s))**.

Signed . . . . Date: . . . . . .

Authorization must be signed by the patient, or by the nearest relative in case of a minor or when the patient is physically or mentally incompetent.

Relationship . . . . . .

PLEASE COMPLETE BOTH SIDES

4-18-12