HEALTH QUESTIONNAIRE

Date_____

Name_____M__F__DOB_____SocSec#_____-_____-_____

Address_____Email_____

Phone: Home_____ Work_____ Cell_____

Marital Status_____ Occupation_____

Spouse's Name_____ Occupation_____

Closest Relative/Emergency Contact_____ Phone_____

Primary Dental Insurance Co_____ Secondary Dental Ins.Co _____
Employer _____ Employer _____
Subscriber _____ Subscriber_____
Subscriber ID _____ Subsciber ID _____
Date of Birth _____ Date of Birth _____
By whom were you referred to our office?_____

In the following questions, circle YES or NO, whichever applies. Your answers are part of the medical information and are considered confidential.

1. Name of primary physician _____ Phone No._____

2. Have there been any changes in your general health in the past year?……..……..Yes No

3. Have you had any surgery requiring hardware/pins/screws?.....Yes No

4. Have you been hospitalized or had a serious illness within the past 5 years?.....Yes No

Explain_____

5. Do you have or have you had any of the following diseases or problems?.....Yes No

a. Rheumatic fever or rheumatic heart disease……..Yes No

b. Congenital heart disease (murmur) ……..Yes No

c. Cardiovascular disease (heart attack, high blood pressure, stroke)……Yes No

d. Heart Valve Replacement ……Yes No

e. Joint Replacement (hip/knee/etc…)……..Yes No

f. Fainting spells or seizures ……...Yes No

g. Diabetes…….Yes No

h. Hepatitis, jaundice or liver disease……Yes No

i. AIDS or HIV seropositive ……..Yes No

{PLEASE FILL OUT OTHER SIDE AND SIGN}

j. Sinus problems ……Yes No

k. Kidney problems ……Yes No

l. Stomach ulcers ……Yes No

6. Do you smoke?……Yes No

7. Do you chew tobacco?……Yes No

8. History of abnormal bleeding associated with previous extractions or surgery……Yes No

9. Have you been treated for cancer?……Yes No

Radiation to head/neck area?……Yes No

10. Are you taking any of the following medications?……Yes No

a. Antibiotics……Yes No

b. Blood thinners (anticoagulants)……Yes No

c. High Blood pressure medications……Yes No

d. Steroids……Yes No

e. Aspirin……Yes No

f. Insulin or diabetic medications……Yes No

g. Others (list please)……Yes No

11. Do you take now, or have you ever taken medications for osteoporosis?……Yes No

12. Are you allergic to any of the following?_____

a. Local anesthetic…… Yes No

b. Penicillin or other antibiotics (specify)……Yes No

c. Valium……Yes No

d. Codeine or other narcotics……Yes No

e. Aspirin……Yes No

13. Women: Are you pregnant?……Yes No

I hereby authorize and request the performance of dental services from Barats Family Dentistry, PC, including the performance of whatever procedures the judgment of the doctor may deem necessary during the performance of any dental procedures that have been mutually agreed upon. Furthermore, I will be responsible for any financial obligations incurred for dental treatment.

Signature of patient (Parent if patient is a minor)_____

Signature of Dentist_____