

Confidential Health Care Questionnaire

Name _____ Date _____
Home Address _____
City _____ Postal Code _____
Birthdate (m/d/year) ____ / ____ / ____ Marital Status _____
Home Phone _____ Business _____
Mobile _____ Email _____
Preferred method of contact (please circle): Home Business Mobile
Occupation _____ Employer _____
Person responsible for this account _____
Name of Dental Insurance _____
Certificate No. _____ Policy No. _____
Family Physician _____ Telephone _____
Referred by Previous Dentist _____
In case of an emergency please notify _____
Relationship to you _____ Telephone _____

Please circle yes or no, give details for 'YES' answers

Have you ever had:

Serious operations and or illness	YES	NO	_____
Heart problems	YES	NO	_____
Pacemaker	YES	NO	_____
Artificial heart valve	YES	NO	_____
High or low blood pressure	YES	NO	_____
Organ Transplant	YES	NO	_____
Cancer, Chemotherapy	YES	NO	_____
Radiation	YES	NO	_____
HIV/AIDS	YES	NO	_____
Seizures/Epilepsy	YES	NO	_____
Diabetes	YES	NO	_____
Tendency to bleed or bruise easily	YES	NO	_____
Liver or Kidney Problems	YES	NO	_____
Hepatitis A B or C	YES	NO	_____

Questionnaire continued on back

Questionnaire continued

Allergies YES NO _____

Asthma YES NO _____

Lung or Breathing Problems YES NO _____

Reaction or Allergies to Medications YES NO _____

Joint Replacement (eg. Hip or knee) YES NO _____

If so what year was this done _____

Aside from regular physicals, are you presently under the care of a Physician

YES NO _____

Are you pregnant, if so what month YES NO _____

Have you or are you being treated for osteoporosis

YES NO _____

Please list any medications you are currently taking _____

Is there anything else concerning your health that the Dentist should know

YES NO _____

OFFICE POLICY

Your appointment time will be reserved especially for you. If you are unable to keep the appointment, we will require 24 hours notice, otherwise it will be necessary to charge a fee for loss time.

Office policy is that services rendered in this office are the financial responsibility of the patient. We cannot accept the direct payment from your insurance company, although we will be pleased to fill out the necessary forms so that you may properly be reimbursed. Please discuss arrangements for payment with the Dentist or receptionist.

Patient's Signature (or parents if under 16) _____