HEALTH QUESTIONAIRE

Date: _____ E-mail Address: _____

Name: _____ Marital Status: S / M / D / W

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Work Phone: (_____) _____ Occupation: _____

Social Security Number: _____ Date of Birth: _____

Person to contact in case of Emergency: _____

Relationship to patient: _____ Daytime telephone number (_____) _____

GETTING TO KNOW YOU
How were referred to our office? ☐ Relative ☐ Friend ☐ Insurance Company ☐ Other
If Relative or Friend please name:

IN ORDER FOR US TO BE ABLE TO PROCESS YOUR INSURANCE, PLEASE COMPLETE ALL OF THE FOLLOWING INFORMATION:

PRIMARY DENTAL INSURANCE COVERAGE

Subscriber Name: _____ Relationship to Patient: _____

Address: _____

Social Security Number: _____ Employer: _____

Date of Birth: _____ Address: _____

Plan Name: _____ Group No: _____

Insurance Company: _____ Address: _____

SECONDARY DENTAL INSURANCE COVERAGE

Subscriber Name: _____ Relationship to Patient: _____

Address: _____

Social Security Number: _____ Employer: _____

Date of Birth: _____ Address: _____

Plan Name: _____ Group No: _____

Insurance Company: _____ Address: _____

Last Dental Visit: _____ Last X-Ray: _____ Last Cleaning: _____

What is your main dental concern? _____

Are you anxious about today's visit? ☐ Yes ☐ No

If yes, what can we do to make you more comfortable? _____

Have you had braces? ☐ Yes ☐ No If yes, when? _____

Have you had gum treatment? ☐ Yes ☐ No If yes, when? _____

THIS QUESTIONAIRE WILL BE USED BY THE DENTIST TO HELP TREAT YOU SAFELY. PLEASE ANSWER ALL QUESTIONS AS ACCURATLEY AS POSSIBLE.

Do you have a history of any of the following: Please circle Yes or No

High Blood Pressure	Y	N	Have you had a blood transfusion?	Y	N	Mentally Disabled	Y	N
Low Blood Pressure	Y	N	Rheumatic Fever	Y	N	Liver Disease	Y	N
Diabetes	Y	N	Heart Murmur	Y	N	Glaucoma	Y	N
Asthma	Y	N	Mitral Valve Prolapse	Y	N	Thyroid Disease	Y	N
Emphysema	Y	N	Stomach Ulcers	Y	N	Epilepsy (Seizures)	Y	N
Cancer	Y	N	Psychiatric Treatment	Y	N	Prosthetic Heart Valve	Y	N
Chemotherapy	Y	N	Tuberculosis	Y	N	Artificial Joints or Organs?	Y	N
Radiation Treatment	Y	N	AIDS or HIV	Y	N	Are you allergic to latex?	Y	N
Heart Disease	Y	N	Sexually Transmitted Disease	Y	N	Do you use tobacco?	Y	N
Heart Attack	Y	N	Kidney Disease	Y	N	Packs Per Day _____		
Stroke	Y	N	Hepatitis B	Y	N	How Long _____		
Bleeding Problems	Y	N	Hepatitis C	Y	N			
Anemia	Y	N	Developmental Delay	Y	N			
Blood Disease	Y	N						
Blood Thinners	Y	N						

Are you addicted to or recovering from Drugs and/or Alcohol? ☐ Yes ☐ No

Do have you have any condition or problem not listed? ☐ Yes ☐ No If yes please list _____

Have you had any of the following in the past year? Please circle Yes or No

Shortness of breath with mild exercise?	Y	N
Shortness of breath while lying down?	Y	N
Chest Pains?	Y	N
Persistent cough or coughing up blood?	Y	N
Severe heat or cold tolerance?	Y	N
Frequent urination or increase thirst?	Y	N
Diet Pills	Y	N

Medical Doctor's Name & Address: _____

Date & Reason for last visit: _____

Name of Previous Dentist: _____ **Telephone:** _____

MEDICATIONS & DOSAGE	SURGERIES/OPERATIONS (Type and Year)
ALLERGIES	**HOSPITALIZATIONS (Reason and Year)**

Pharmacy Name and Location _____

Telephone _____

Have you ever been treated or are you currently taking medication to prevent any of the following condtions?

Please circle Yes or No:

Osteoporosis	Y	N
Bone Disease	Y	N
Osteogenesis Imperfecta	Y	N
Bone Cancer	Y	N
Paget's Disease	Y	N
Myeloma	Y	N
Multiple Myeloma	Y	N

Are you taking any of the following medications?

Bisphosphonates	Y	N
Fosomax	Y	N
Didronel	Y	N
Aredia	Y	N
Actonel	Y	N
Zometa	Y	N
Boniva	Y	N

WOMEN ONLY

6. Are you presently taking birth Control pills?	Yes	No
7. Is there any possibility you are pregnant?	Yes	No
8. Are you presently breastfeeding?	Yes	No

CONSENT

I _____ authorize the doctor and/or his aides to take x-rays, study models and photographs. I furthermore authorize the doctor to perform any and all forms of treatment, use local anesthetic and any other medication therapy deemed necessary. I understand I am responsible for payments of dental service for myself and my dependants., payable at the time of service unless financial arrangements have been made. Holdbrook Pediatric Dental accepts insurance assignments as a courtesy to me and I am responsible for any cost insurance does not pay.

At Holdbrook Pediatric Dental we are dedicated to staying on schedule for the benefit of our patients. To accomplish this we do not double-book your appointment. The time given is reserved for you. We ask that you help us by keeping your appointments on time. We require 24 hours notice if you find you must change your appointment.

Patient Signature _____ **Date** _____
Signature of Responsible Party _____
Relationship to Patient _____