bigheart
FAMILY DENTISTRY

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Patient Information

Date _____ email: _____

Patients Name _____
Last First Middle Sex

Address _____
Street City State Zip

Home Phone _____ Cell Phone _____ DOB _____ SS# _____

Previous Denist _____ Last Dental Vist _____

Occupation _____

Spouse's Name _____ DOB _____ Celll Phone _____

If patient is a minor give parents's or guardian's name _____

Whom may we thank for referring you to our office? _____

Responsible Party Information if other than patient

Name _____
Last First Middle Sex

Address _____
Street City State Zip

Home Phone _____ Cell Phone _____

Relationship to Patient _____

Dental Insurance Information

Insured's Name _____ DOB _____ Insured's SS# _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Company Address _____ Phone # _____

Do you have dual coverage?

Insured's Name _____ DOB _____ Insured's SS# _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Company Address _____ Phone # _____

Emergency Information

Person to contact not living with you _____ Relationship _____

Home Phone _____ Cell Phone _____

Signature (Parent's signature if minor) _____

Updates (date & initial) _____

Please Complete Reverse Side of Form

HEALTH QUESTIONAIRE

Answers to the following questions are for our records only and will be considered confidential.

1. Are you in good health.....YES NO
   • Has there been a change in your general health within the past year.....YES NO
2. My last physical examination was on
3. Are you now under the care of a physician.....YES NO
   • If so, what is the condition being treated
4. The name and address of the physician is
5. Have you had any serious illness or operation.....YES NO
6. Have you been hospitalized or had a serious illness within the past five (5) years.....YES NO
   • If so, what was the problem
7. Do you have or have you had any of the following disesases or problems
   • Rheumatic fever or rheumatic heart disease .....YES NO
   • Congential heart lesions..... YES NO
   • Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure arterioscierosis, stroke ..... YES NO
   1) Do you have pain in chest upon exertion ..... YES NO
   2)Are you ever short of breath after mild excercise ....YES NO
   3) Do your ankles swell.....YES NO
   4) Do you get short of breath when you lie down, or do you require extra pillows when you sleep.....YES NO
   • Asthma.....YES NO
   • Hives or skin rash.....YES NO
   • Fainting spells or seizures..... YES NO
   • Diabetes.....YES NO
   1) Do you urinate (pass water) more than six times a day.....YES NO
   2) Are you thirsty much of the time.....YES NO
   3) Does your mouth frequently become dry.....YES NO
   • Hepatitis/Type..... YES NO
   • Arthritis.....YES NO
   • Inflammatory rheumatism (painful swollen joints)..... YES NO
   • Stomach ulcers.....YES NO
   • Kidney trouble.....YES NO
   • Tuberculosis.....YES NO
   • Do you have a persistent cogh or cough up blood..... YES NO
   • Low blood pressure.....YES NO
   • Venereal Disease.....YES NO
8. Have you had abnormal bleeding assoiated with previous extractions, surgery, or trauma .....YES NO
   • Do you bruise easily.....YES NO
   • Have you ever required a blood transfusion .....YES NO
   If so, explain the circumstance
9. Do you have any blood disorder such as anemia.....YES NO
10. Have you had surgery or x-ray treatment for a tumor, growth, or other condition of your mouth or lips.....YES NO
11. Are you taking any drug or medicine.....YES NO
    Please supple med list and does
12. Are you taking any of the following:
    • Antibiotics or sulfa drugs.....YES NO
    • Anticoagulants (blood thinners).....YES NO
    c. Medicine for high blood pressure.....YES NO
    • Cortisone (steroids).....YES NO
    • Tranquilizers.....YES NO
    • Aspirin.....YES NO
    • Insulin, tolbutamide (orinase) or similar drug.....YES NO
    • Digitalis or drug for heart trouble.....YES NO
    • Nintroglycerin..... YES NO
    • Other
13. Are you allergic or have you reacted adversely to:
    • Rheumatic fever or rheumatic heart disease.....YES NO
    • Pennicillin or otehr antibiotics.....YES NO
    • Sulfadrugs.....YES NO
    • Barbiturates, sedatives, or sleeping pills.....YES NO
    • Aspirin.....YES NO
    • Iodine..... YES NO
    • Other
14. Have you had any serious trouble associated with any previouse treatment.....YES NO
    If so, explain
15. Do you have any disease, condition, acquired immune disease, or problem not listed above that you think we should know about
    If so, explain
16. Have you had surgery for prosthetic implants (hip, knee, etc.).....YES NO
    If so, explain

    Date
17. Are you employed in any situation which exposes you regulary to x-rays or other ionizing radiation.....YES NO
18. Are you pregnant.....YES NO
19. Do you have any problems associated with your menstral period.....YES NO

Remarks:

_____

SIGNATURE OF PATIENT