ADULT HEALTH QUESTIONAIRE

The data on this confidential questionnaire is essential to render the best professional care. We appreciate your co-operation in filling it out carefully, so that we will have accurate records. PLEASE PRINT. THANK YOU

PATIENT'S LAST NAME	MR. MRS. MISS MS DR. FIRST NAMES	HOME PHONE

APPT. #	ADDRESS	CITY	POSTAL CODE	CELL PHONE

DATE OF BIRTH MONTH DAY YEAR	MARITAL STATUS	HEALTH CARD NUMBER	

OCCUPATION	EMPLOYER

BUSINESS ADDRESS	BUSINESS PHONE # LOCAL

YOUR HUSBAND/WIFES'S NAME	HIS/HER OCCUPATION	BUSINESS PHONE # LOCAL

HIS/HER EMPLOYER	ADDRESS

NAME OF FAMILY MEMBER RESPONSIBLE FOR PAYMENT OF YOU ACCT.	WHOM MAY WE THANK FOR REFERRING YOU TO THIS OFFICE

DO YOU HAVE DENTAL INSURANCE COVERAGE	NAME OF INSURANCE COMPANY	NAME OF ADMINISTRATIVE COMPANY (IF ANY)

PHYSICIAN'S NAME	OFFICE PHONE #

OFFICE POLICY

Your appointment time will be reserved especially for you. **If you are unable to keep the appointment we will require 48 hours notice, otherwise it will be necessary to charge for this time lost. Services are paid for each visit as they are performed.** However in certain circumstances consulting the doctor may make arrangements for payments.

Please circle one of the following numbers.

1. I have dental insurance
2. I wish to know the total fee for all the work to be done, to make special arrangements for payment as well as the number of appointments necessary so that I can pay equal portions at each appointment.
3. I wish to pay each visit as the services are performed

Current State of Health. Please CIRCLE the correct answers.
GIVE DETAILS where indicated.

When did you have your last medical examination? _____

Are you under treatment by your physician	No	Yes…….
Are you taking any medication?	No	Yes…….

Specifically – DO YOU HAVE, or HAVE YOU EVER HAD:

Any Serious Illnesses?	No	Yes…….
Any Serious Operations?	No	Yes…….
Heart, or blood pressure problems?	No	Yes…….
Blood Disorders or bleeding tendencies?	No	Yes…….
Rheumatic fever?	No	Yes…….
Lung or Breathing problems	No	Yes…….
Liver, or kidney Problems	No	Yes…….
Stomach, or intestinal problems	No	Yes…….
Fainting or dizzy spells	No	Yes…….
Diabetes?	No	Yes…….
Epilepsy?	No	Yes…….
Allergies to Food, Skin rash, Hayfever Other	No	Yes…….

Unfavorable Drug Reactions, or Allergies

Local Anesthetic ("Freezing")	No	Yes…….
General Anesthetic?	No	Yes…….
Penicillin?	No	Yes…….
Erythromycin?	No	Yes…….
Other Antibiotics?	No	Yes…….
Aspirin?	No	Yes…….
Codeine?	No	Yes…….
Tranquilizers, sedatives, pain killers	No	Yes…….
Have you had ANY warnings against taking ANY medications?	No	Yes…….
Do you Smoke?	No	Yes…….
Do you use Alcohol?	No	Yes…….
Do you drink Tea or Coffee	No	Yes…….
Is there anything ELSE concerning your health that I should know	No	Yes…….

When was your last visit to the Dental Office? ……

For Women: Are you pregnant? No Yes Expect in……..

DATE: _____ **SIGNATURE: _____**