HEALTH QUESTIONNAIRE Date _______________ Phone: home ______________________________
Name ____ work ________________________________
Last First Middle cell ________________________________
Address ____
Number Street City State Zip
Date of Birth ___________ Age _____ Height ______ Weight ______ Smoke ______ Per Day ________
Occupation & Place of Employment ____________________________ E-Mail ________________________
S.S.# ____________________________________ Drivers License # ______________________________
Marital Status ______________ Spouse _______________ Occupation _____________________________
Referred here by ___________________ Dentist _________________ Physician ____________________
If patient is a dependent: Father's name _____________________ Occupation ______________________
Mother's Name ____________________ Occupation ______________________
Parent's Address ____
Method of Payment Cash ________ Check ________ VISA / MasterCard ___________________________
Fees are due at the time of service unless specific arrangements have been made.
HMO patients authorization needed at time of visit or patient will be billed.
Insurance Carrier ____ Monthly Late Charge 1.5%
Please answer the following questions: Circle One
(Women) Are you pregnant? yes no
Are you allergic to penicillin, codeine, aspirin, any drugs, medications, egg or soy products?
If yes, list ____ yes no
Have you taken any medications during the past year?
If yes, list ____ yes no
Have you been a patient in the hospital during the past 2 years?
If yes, why? ____ yes no
Have you been under the care of a physician during the past 2 years?
If yes, why? ____ yes no
Circle any of the following that apply to you.

heart trouble	diabetes	sinus trouble	herbal supplements
congenital heart lesions	hepatitis	arthritis	asthma
heart murmur	jaundice	tuberculosis	ulcer
rheumatic fever	glaucoma	anemia	cancer
scarlet fever	porphyria	excessive bleeding	
high blood pressure	immune disorder	contact lenses	
blood thinners	stroke	persistent cough	
artificial body part	epilepsy	psychiatric treatment	

Have you had any other serious illnesses? If yes, list ____
Difficulties with previous anesthetics? If yes, list ____

Patients receiving sedation or general anesthesia:
Have you had anything to eat or drink within the past 6 hours? ___________________________________
Who is driving you home today? Name ____
DRIVER MUST REMAIN IN OUR OFFICE BUILDING DURING THE PROCEDURE
We are committed to protecting your medical information. Your signature allows us to file your insurance, obtain or disclose information relating to treatment, payment and healthcare operations.
The detailed Notice of Privacy Practices is available upon request.

Signature_________________________________