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Family - Cosmetic - Implant Dentistry

CONFIDENTIAL HEALTH HISTORY AND PATIENT INFORMATION QUESTIONNAIRE

In order for us to better serve you, please fill in the following information completely: Date: _____
(Complete Both Pages) Front & Back

If patient is a child, please answer both employment information for each parent.

Patient's Name
Mr. Mrs. Ms. Miss _____ Patient Date of Birth: _____ Age: _____

Residence
Address: _____ City: _____ Zip: _____

How long: _____ Home Phone: _____ Patient/Parent Cell Phone _____

Patient/Parent
Occupation: _____ E-mail _____

Patient/Parent
Work Phone _____ City: _____ Zip: _____

Spouse/Parent
Name: _____ Cell Phone _____ Work Phone _____

Spouse/Parent
Occupation _____ E-mail _____ _____

Person Financially Responsible: _____ Relation to Patient: _____

Patient/Parent
Social Security #: _____ Drivers License #: _____

Previous Dentist's Name: _____

** **Whom May We Thank for Referring You?** _____

Chief Dental Complaint: _____

In the following questions, circle yes or no whichever applies. Your answers are for our records only and will be considered confidential.

Are you in good health? YES NO

2. Has there been any change in your general health within the past year? YES NO
3. Are you now under the care of a physician? YES NO
   a. If so, what is the condition being treated? _____
4. The name, address and phone number of my physician is:
5. Have you had any serious illness or operations?
   a. If so, what was the operation? _____
6. Have you been hospitalized or had a serious illness within the past five (5) years? YES NO
   a. If so, what was the problem? _____
7. Do you have or have you had any of the following:
   a. Rheumatic fever, rheumatic heart disease or scarlet fever YES NO
   b. Congenital heart lesions YES NO
   c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriorscierosis, stroke) YES NO
      1. Have you lost or gained more than 10 pounds in the last year YES NO
      2. Do you have pain in chest upon exertion? YES NO
   d. Allergy YES NO
   e. Sinus trouble YES NO
   f. Asthma, hay fever, or emphysema YES NO
   g. Hives or a skin rash YES NO
   h. Fainting spells or seizures YES NO
   I. Diabetes YES NO
      1. Do you have to 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
   j. Hepatitis, jaundice, liver disease, or thyroid disease YES NO
   k. Arthritis YES NO
   l. Inflammatory rheumatism (painful swollen joints) YES NO
   m. Stomach ulcers YES NO
   n. Kidney trouble YES NO
   o. Tuberculosis YES NO
   p. Do you have a persistent cough or do you cough up blood? YES NO
   q. Mitral valve prolapse? YES NO
8. Are you on a special diet? YES NO
9. Are you ever short of breath after mild exercise? YES NO
10. Do your ankles swell? YES NO
11. Do you get short of breath when you lie down, or do you require extra pillows when you sleep? YES NO
12. Do you have a cardiac pacemaker? YES NO

13. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? YES NO
    a. Do you bruise easily? YES NO
    b. Have you ever required a blood transfusion? YES NO
    If so, explain the circumstances: _____
14. Do you have any blood disorder such as anemia, or sickle cell disease? YES NO
15. Have you ever tested positive for HIV or AIDS? YES NO
16. Have you had surgery or x-ray treatment for a tumor, growth, or other condition? YES NO
17. Are you taking any drug or medication? YES NO
    If so, what? _____
18. Are you taking any of the following:
    a. Antibiotics or sulfa drugs YES NO
    b. Anticoagulants (blood thinner) YES NO
    c. Medicine for high pressure YES NO
    d. Cortisone (steroids) YES NO
    e. Tranquilizers YES NO
    f. Antihistamines YES NO
    g. Aspirin YES NO
    h. Insulin, tolbutamide (Orinase) or similar YES NO
    I. Digitalis or drugs for heart trouble YES NO
    j. Nitroglycerin YES NO
    k. Oral contraceptive other than hormone therapy YES NO
    l. Other _____
19. Are you allergic or have you reacted adversely to:
    a. Local anesthetics YES NO
    b. Penicillin or antibiotics YES NO
    c. Sulfa drugs YES NO
    d. Latex gloves YES NO

19. (continued)
    e. Barbiturates, sedatives or sleeping pills YES NO
    f Aspirin YES NO
    g. Iodine YES NO
    h Codeine or other narcotics YES NO
    I Drug or alcohol addiction YES NO
    j Other: _____
20. Have you had any serious trouble associated with any previous dental treatment? YES NO
21. Do you have any disease, condition, or problem not listed above that you think I should know about? YES NO
    If so, explain: _____
22. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation? YES NO
23. Are you wearing contact lenses? YES NO
24. Do you have any artificial joints, heart valves, heart murmur, heart disease or heart attack? YES NO
25. Have you ever been advised by your physician or Dentist that you need antibiotic pre-med for dental treatment? YES NO
26. Have you ever had an injury to your head, neck or face? YES NO
27. Do you have any pain in your jaw or jaw joints? YES NO
28. Do you smoke? YES NO
29. Are you pregnant? YES NO
30. Do you have problems associated with your menstrual period? YES NO
31. Are you nursing? YES NO
32. Are you taking bisphosphonates (fossamax, boniva, aredia, etc. If so, when _____
    For How long? _____
33. Are you currently under psychiatric care? YES NO

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medications changes, I will, without fail, inform the doctor of dentistry at my next appointment.

Patient/Parent signature _____ Date: _____

Initial Treating Dentist _____ Date: _____

Medical Update _____ Medical Update _____

Medical Update _____ Medical Update _____

CONSENT

I hereby authorize Dr. Fong and his staff to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. I also authorize Dr. Fong to perform any and all forms of treatment and therapy that may be indicated. I understand that the use of anesthetic agents embodies a certain risk. I also understand that my dental insurance is a contract between myself and the insurance carrier and not between the insurance carrier and Dr. Fong. Therefore, I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I assign all insurance benefits to Dr. Fong. I further understand that a late charge will be added to any overdue balance.

Patient/Parent Signature _____ Date: _____ DENTIST Signature _____