HEALTH QUESTIONNAIRE

Date_____

Name (Last) _____ (First) _____ (middle) _____

Address _____

City _____ State _____ Zip Code _____

Phone (Home)_____ (Business) _____

Date of Birth_____ Sex _____ Height _____ Weight _____

Occupation_____ Married _____ Spouse _____ Single _____

Closest Relative _____Phone _____

If you are completing this form for another person, what is your relationship to that person? _____

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

1. Has there been any changes 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
   a. if so, what is the condition being treated? _____
4. The name and address of my physician is _____

   _____
5. Have you had any serious illness or operation? YES NO
   a. If so, what was the illness or 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? _____

Please circle choice.

7. Do you have or have you had any of the following diseases or problems: YES NO
   a. Rheumatic fever or rheumatic heart disease? ..... YES NO
   b. Congenital heart lesions? .....
   c. Cardiovascular disease, heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arthrosclerosis, stroke? ..... YES NO
      1) Do you have pain In chest upon exertion? ..... YES NO
      2) Are you ever short of breath after mild exercise? ..... YES NO
      3) Do your ankles swell? ..... YES NO
      4) Do you get short of breath when you lie down or require extra pillows when you sleep? ..... YES NO
   d. Allergy? ..... YES NO
   e) Sinus trouble? ..... YES NO
   f) Asthma or hay fever? ..... 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

Please circle choice.

j. Hepatitis, jaundice or liver 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 cough up blood? ..... YES NO
q. Low blood pressure ..... YES NO
r. Venereal disease? ..... YES NO

s. Other?_____

B. 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 _____

_____

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

If so, what_____

12. Are you taking any of the following:
a. Antibiotics or sulfa drugs? ..... YES NO
b. Anticoagulants (blood thinners)? ..... YES NO
c. Medicine for high blood 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 drug? ..... YES NO
i. Digitalis Or drugs for heart trouble? ..... YES NO
j. Nitroglycerin? ..... YES NO
k. Other? _____

13. Are you allergic or have you reacted adversely to:
a. Local anesthetics? ..... YES NO
b. Penicillin or other antibiotics? ..... YES NO
c. Sulfa drugs? ..... YES NO
d. Barbiturates, sedatives, or sleeping Pills? ..... YES NO
e. Aspirin? ..... YES NO
f. Iodine? ..... YES NO
g. Codeine or other narcotics? ..... YES NO

h. Other? _____

14. Have you had any serious trouble associated with any previous dental treatment? ..... YES NO

If so, explain?_____

_____

15. Do you have any disease, condition, or problem not listed above that you think i should know about? .. YES NO

If so, explain?_____

_____

16. Are you employed in any situation which exposes you regularly to x-ray$ or other ionizing radiation? .. YES NO
17. Are you wearing contact lenses? ..... YES NO

WOMEN

18. Are you pregnant? ..... YES NO
19. Do you have any problems associated with your menstrual period? ..... YES NO

REMARKS:

Signature of Patient / Guardian_____ Date _____

DENTAL TREATMENT CONSENT FORM

Please read and initial the items checked below and read and sign the section at the bottom of form.

Print Name: _____ **Date of birth** _____

☐ **1. WORK TO BE DONE**

_____ _____ _____ _____

_____ _____ _____ _____

(Initials_____)

☐ **2. DRUGS AND MEDICATIONS**

I understand that antibiotics and analgesia and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). (Initials_____)

☐ **3. CHANGES IN TREATMENT PLAN**

I understand that during treatment It may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy fallowing routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary. (Initials_____)

☐ **4. REMOVAL OF TEETH**

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth _____ and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove alt the infection, if present. and it may be necessary to have further treatment, understand the risks Involved in having teeth removed, some of Which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue Paresthesia) that can last for an indefinite period of time (days or months) or fractured taw. I understand I may need further treatment by a specialist or even hospitalization it complications arise during or following treatment, the cost of which is my responsibility. (Initials_____)

☐ **5. CROWN, BRIDGES AND CAPS**

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that t must be careful to ensure that they are kept on until the permanent crowns are dowered. I realize the final opportunity to make changes in my new crown, bridge or cap (Including shape, fit, size, and color) will be before cementation. (Initials_____)

☐ **6. DENTURES, COMPLETE OR PARTIAL**

I realize that kill or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing those appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes In my new dentures (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relirog approximately three to twelve months after initial placement. The cost for this procedure is not included in the Initial denture fee. (Initials_____)

☐ **7. ENDODONTIC TREATMENT (ROOT CANAL)**

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment, I understand that occasionally additional surgical procedures may be necessary following root canal treatment (aplcoectomy). (Initials_____)

☐ **8. PERIODONTAL LOSS (TISSUE & BONE)**

I understand that I have a serious condition, causing gum and bone Infection or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition. (Initials_____)

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction, I consent to the proposed treatment.

Signature of Patient / Guardian_____ Date _____