HEALTH QUESTIONNAIRE

1. Are you in good health? 2. Has there been any change in your health within the past year? 3. Date of last physical exam 4. Are you now under medical care? 5. Have you ever had a serious illiness? 6. Do you have (or had) any of the foliowing? 6. Do you have (or had) any of the foliowing? 6. Do you have (or had) any of the foliowing? 6. Do you have (or had) any of the foliowing? 6. Do you have for had) any of the foliowing? 6. Do you have for had) any of the foliowing? 6. Do you have for had) any of the foliowing? 6. Do you have for had) any of the foliowing? 6. Do you have for had) any of the foliowing? 6. Do you have for had) any of the foliowing? 6. Do you have for had) any of the foliowing? 6. Do you have for had) any of the foliowing? 6. Do you have for had) any of the foliowing? 6. Do you have for had) any of the foliowing? 6. Do you have for had) any of the foliowing? 6. Do you have for had) any of the foliowing? 6. Do you have or shift of hearth disease. 7ES NO 7ES	NAME	DATE
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B. Blood thinners	A. Antibiotics or sulfa drugsYES N	
C. High blood pressure medicineYES NO D. Cortisone or steroidsYES NO E. Aspirin or anti-inflammatory drugsYES NO F. Insulin, Orinase or similar drugYES NO G. Digitalis or heart drugsYES NO H. NitroglycerinYES NO I. NarcoticsYES NO VOMEN ONLY- 1. NarcoticsYES NO YES NO WOMEN ONLY- 31. Are you pregnant or think you might be?	B. Blood thinnersYES N	iO if not, why?
D. Cortisone or steroids YES NO 29. Are you employed in a job which exposes E. Aspirin or anti-inflammatory drugs YES NO you to x-rays or radiation YES NO F. insulin, Orinase or similar drug YES NO G. Digitalis or heart drugs YES NO H. Nitroglycerin YES NO WOMEN ONLY- I. Narcotics YES NO 31. Are you pregnant or think you might be?	C. High blood pressure medicineYES	NO
E. Aspirin or anti-inflammatory drugsYES NO you to x-rays or radiationYES NO F. insulin, Orinase or similar drugYES NO G. Digitalis or heart drugsYES NO H. NitroglycerinYES NO WOMEN ONLY- I. NarcoticsYES NO 30. Do you wear contact lensesYES NO WOMEN ONLY- 31. Are you pregnant or think you might be?	D. Cortisone or steroidsYES N	10 29. Are you employed in a job which exposes
F. insulin, Orinase or similar drugYES NO 30. Do you wear contact lensesYES NO G. Digitalis or heart drugsYES NO H. NitroglycerinYES NO WOMEN ONLY- 1. NarcoticsYES NO 31. Are you pregnant or think you might be?	E. Aspirin or anti-inflammatory drugsYES. N	VO you to x-rays or radiationYES NO
G. Digitalis or heart drugsYES NO H. NitroglycerinYES NO WOMEN ONLY- I. NarcoticsYES NO 31. Are you pregnant or think you might be?	F. insulin, Orinase or similar drugYES N	NO 30. Do you wear contact lensesYES NO
H. NitroglycerinYES NO WOMEN ONLY- I. NarcoticsYES NO 31. Are you pregnant or think you might be?	G. Digitalis or heart drugsYES N	10
I. Narcotics YES NO 31. Are you pregnant or think you might be?	H. NitroglycerinYES N	10 WOMEN ONLY-
	I. NarcoticsYES N	10 31. Are you pregnant or think you might be?
J. Birth control pillsYES NO TES NO	J. Birth control pills YES N	

-PATIENT REGISTRATION-

Date	
Patient's Name	Birthdate
Marital status Sex	K M F Social Security #
Residence address	Home Phone #
•	
Employed by	Address rrent employment
Phone Years at cur	rrent employment
Name of spouse	
Spouse employed by	Spouse social security #
Whom may we thank for referring	you?
	•
Person responsible for paying acco	ount:
Name	Relation to patient
A ddress	
Dental Insurance Information:	
Teaurence company name	
Insurance company address	
Group #	Policy#
Insured's name	Relationship to patient
Insured's birthday	SS#
Insurou 3 on anny	
Physician name	
Address	
•	
Telephone number	
Whom may we contact in case of	an emergency?
FROME MUMOEI	another person, what is you relationship?
if you are thing out this form for	amouter person, what is you relationship:
	at a transfer of the form in normant to the
I understand that the information	that I have given on both sides of this form is correct to the held in the strictest confidence, and it is my responsibility to
	nem in the strictest contidence, and it is my responsibility to
best of my knowledge, that it will be	medical section. I also such cuins the deutal staff to noufer
inform this office of any changes in n	my medical status. I also authorize the dental staff to perform
inform this office of any changes in the necessary dental services that I n	my medical status. I also authorize the dental staff to perform
inform this office of any changes in n	my medical status. I also authorize the dental staff to perform