HEALTH QUESTIONNAIRE

MEDICAL HISTORY:

1. How would you describe your overall health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
2. Date of last physical examination_____Primary care Physician:_____
3. Are you now under the care of a Specialty care physician? Physician/Number _____
   If Yes, Condition being treated_____
4. Have you been Hospitalized In the past 5 years? When and Why?_____
5. Have you ever taken medicine for Osteoporosis? Yes No Drug Name_____ Was the Drug Take in pill or IV_____
6. Are you **Sensitive or Allergic to any Drugs**? ☐ Penicillin ☐ Tetracycline ☐ Sulfa Drugs ☐ Aspirin ☐ Codeine
   ☐ Other Drug Allergies_____
7. List all **Current Medications & Conditions**: _____
   _____

8. Please indicate if you have EVER had any of the following: Circle Yes or No to any known conditions:

High Blood Pressure	Yes No	Tuberculosis	Yes No	Thyroid Condition	Yes No
Diabetes: Type 1 or 2	Yes No	Heart Disease	Yes No	Asthma/Hay fever	Yes No
Acid Reflux/GERD	Yes No	Low Blood Pressure	Yes No	Respiratory Disease	Yes No
Heart Attack: (Year_____)	Yes No	Osteoporosis/Osteopenia	Yes No	Difficulty Swallowing	Yes No
Stroke: (Year_____)	Yes No	Fainting Spells/Dizziness	Yes No	Dry Mouth	Yes No
Bruxism/Grinding	Yes No	Excessive Thirst/Urination	Yes No	Bad Breath	Yes No
Snoring	Yes No	Excessive Bleeding	Yes No	Use Mints	Yes No
Excessive Tiredness	Yes No	Arthritis	Yes No	Use Antacids	Yes No
Sleep Apnea	Yes No	Rheumatoid Arthritis	Yes No	Cold Sores	Yes No
CPAP Machine	Yes No	Drug Addiction	Yes No	Canker Sores	Yes No
TMD (Jaw Joint Pain)	Yes No	Alcoholism	Yes No	Smoke Cigarettes	Yes No
Hepatitis: A B C	Yes No	Epilepsy/Seizures	Yes No	Smoke Cigars	Yes No
Blood Diseases	Yes No	Cancer: _____	Yes No	Smokeless Tobacco	Yes No
Kidney Disease	Yes No	Chemotherapy _____	Yes No	AIDS/HIV	Yes No
Bacterial Endocarditis	Yes No	Auto Immune Disorder	Yes No	Venereal Disease	Yes No

9. Any Disease or Condition above not listed that you think we should know about?_____
10. Have you ever had a **joint, hip or knee replacement**? Yes No Year_____ **Premedication**? Yes No _____
11. Have you ever had a **Heart Attack or Heart Surgery**? Yes No Year_____

WOMEN: Are you: ☐ Pregnant Due Date:_____ ☐ Nursing

Do you Use: ☐ Oral Contraceptives ☐ Hormone Replacement Therapy

DENTAL HISTORY:

1 Have you ever had **Periodontal Therapy (Deep Cleaning)** for Periodontal Disease? Year_____ Perio Surgery? Yes No
How many times a year do you see a Hygienist for Perio Maintenance?_____ Last Visit_____

2. Have you ever had any unfavorable reaction to Local Anesthetic? Yes No Do you have trouble getting numb? Yes No

3.Do you have any sensitivity to: ☐ Hot ☐ Cold ☐ Sweets ☐ Biting Pressure

4. Times a day you brush?_____ Times a week you Floss? _____ Other _____

7. Have you ever had serious trouble associated with Dental Treatment? Yes NO If Yes, please explain _____

8. Does Dental Treatment make you nervous? Yes No If Yes, please explain_____

CONSENT FOR TREATMENT: I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History Form, to administer any treatment; use of Diode Laser, or to administer such anesthetics, analgesics, sedatives, and nitrous sedation; and to perform such procedures as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of possible complications of the procedures, anesthetics and/or drugs.

"All services are rendered and accepted under the terms and conditions printed on the reverse of here."

Signature: _____ **Date:**_____

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when a patient is physically or mentally incompetent.

Relationship to Patient:_____

WAGER EVANS DENTAL

PATIENT INFORMATION

Patient Name (Print)_____ Age_____ □ Married □ Single
Last First Initial

If patient is a minor, list Parent/Guardian name:_____

Residence Address _____City _____State_____ Zip_____

Date of Birth _____Social Security No. _____Email_____

Residence Phone_____ Cell Phone _____Preferred Method of Contact_____

Employer_____Occupation_____ Bus Phone_____

If a Student, Name of School/College _____

Spouse_____

Spouse Employer_____Occupation_____Bus Phone_____

General Physician_____Phone_____Pharmacy/Phone_____

OtherPhysician_____Specialty_____Phone_____

Former Dentist _____ Date of last Dental Visit_____

Emergency Contact_____Relationship_____Phone_____

Date of Last Full Set of Dental X-rays _____Purpose of Today's Dental Visit_____

Whom may we thank for referring you?_____

Financial Information

*Please provide Insurance Card to copy for your file.

Person Responsible for this account:_____Relationship_____

Address:_____City_____State_____

Dental Insurance Company _____Name of Insured:_____

Employer:_____Position:_____

Group Number _____SS# of Insured_____ Date of Birth_____

Secondary Dental Insurance Company and Information:_____

Patients who carry Dental Insurance understand that all dental services are charged directly to the patient and that he/she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms to assist in making collections from insurance companies, and we will credit such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by the insurance company. _____(Initial)

I realize that failure to keep this account current may result in our office not being able to provide additional dental services. In case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on any delinquent or future account balances. _____(Initial)

Patients with a medical history or symptoms indicative of an undiagnosed active disease will be promptly referred to their physician and deferred from office treatment until their physician confirms that the patient does not have a communicable disease or is no longer infectious and is cleared to continue with dental treatment. _____(Initial)

A missed dental appointment presents problems for us both. For you, a missed dental appointment causes a delay in treatment that was recommended to help improve your dental health and prevents us from scheduling another patient that could benefit from treatment. We charge a $85 missed appointment fee for failed appointments that you as the patient is responsible for paying if we are not notified within 24 hours of missed appointment. _____(Initial)

Signature_____ Date _____