Lafazanos Dental

for the life of your smile

WELCOME TO OUR OFFICE

Your health history is important to us. In order that we may provide you with the best possible dental services, please answer all questions completely and accurately as incorrect information may compromise your treatment. This Health History Questionnaire will become a part of your dental treatment record and is confidential.

PATIENT INFORMATION

Last Name ________________________________ First Name ___________________________ Middle Initial___

Address ____

City____ State _________ Zip ___________

Birthday___________________ Age:_____________ Sex: Male__ Female__ SS#__________________________

Homephone #: ___________________________________ Cellphone #: _________________________________

E-mail: ____

Employer: _____________________________ Occupation: _____________________

Name of Parent/Guardian (if patient is a minor): ______________________________ Relation: _______________

Emergency Contact Name: ______________________________________ Phone:__________________________

INSURANCE INFORMATION

Insurance Company: _______________________________________ Group Number: _______________________

Insurance Co. Address: _______________________________________ Telephone #: _______________________

Insured Identification Number: _________________________________ Plan Number: _____________________

Primary Insured's Name: ____________________________________ Birthday: __________________________

Social Security Number: ____________________________ Relation to Patient: ____________________________

Signature of Insured: x _______________________________________ Date: __________________

DENTAL HISTORY

Former Dentist: ________________________________

Date of Last Dental care: ________________________ Date of Last X-Rays:________________________________

Have you had problems with any of the following: (Indicate with Check)

- Bad Breath
- Clicking or popping jaw
- Sensitivity to Cold/Heat/Sweets
- Clicking or Popping Jaw
- Bleeding Gums
- Grinding/Clenching of Teeth
- Periodontal Treatment
- Sores or Growths in Mouth
- Sensitivity when Biting

How often do you brush? ______________________

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure?

____

What would you like us to do today? ____

Are you in any dental discomfort today? ____

MEDICAL HISTORY

Physician's Name____________________________________ Phone Number ________________________________

Address ____ Date of Last Visit __________________________________

Have you had any serious illness, operation or been hospitalized? ____ If yes describe________________________

Are you currently under the care of a physician? (Circle) Yes No If yes explain____________________________

Have you ever had a blood transfusion? _____ If yes describe ____

Have you ever taken Fen-Phen/Redux? __________________

Women: Are you pregnant? ________ Nursing? ________ Taking birth control pills? ________

Has there been any change in your health in the last two (2) years? (circle) Yes No If yes, please explain

____

Have you ever had an allergic reaction? ____

List any allergies to Drugs/Medications, Food, Latex Products Other: _____________________________________

MEDICAL HISTORY CONTINUED

Have you ever had or have been treated for … (circle all that apply)

AIDS/HIV	Cough, persistent	Liver disease	Shortness of breath
Anemia	Diabetes	Mitral valve prolapse	Skin rash
Arthritis	Epilepsy	Nervous problems	Spina Bifida
Artificial heart valves	Fainting	Pacemaker/Heart surgery	Tuberculosis
Artificial joints	Heart Murmur	Psychiatric care	Other: ____________
Asthma	Heart Problems____	Radiation treatment	____________
Blood Disease	Abnormal bleeding	Respiratory disease	
Back problems	Herpes	Stroke	
Cancer	Hepatitis	Surgical implant	
Chemical dependency	High blood pressure	Thyroid	
Chemotherapy	Kidney disease		

Please Answer the Following Questions

Do you now or have you ever used tobacco? Yes No

If you currently use tobacco, are you interested in quitting? Yes No

How many alcoholic drinks do you consume in: a day? _____ a week? _____ a month?_____

MEDICATIONS

Please List All Medications you are currently taking (Over-the-Counter and Prescribed):

____

____

____

____

AUTHORIZATION

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by Lafazanos Dental to help determine appropriate and healthful dental treatment. If there is any change in my medical status I will inform the dentist.

I authorize the insurance company indicated on this form to pay Lafazanos Dental all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize Lafazanos Dental to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature X ____ Date _________________________

Payment is due in full at time of treatment, unless prior arrangements have been approved.