Lafazanos Dental

For the life of your smile.

WELCOME

Your health history is very 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 considered "Confidential."

Date: __________________

Patient Information

Last Name ______________________________________ First Name ____

Address ____

City____ State __________ Zip ___________

DOB_____________________Age:_____________ Sex: Male__ Female__ SS#___________________________

Home phone#:_______________________________________Cell#_______________________________

Email: ____

Patient employed by:______________________________Occupation:______________________

If patient is a minor: Name of parent/guardian____

Relationship to patient: ______________________

In case of an emergency notify:___________________________________ Phone:___________________________

Insurance Information

Insurance Co: ____________________________________ Group #__________________________

Insurance Co. Address: ____
Tel#_______________________________

Insured ID#________________________________ Plan#_______________________

Primary Insured's Name: ____ DOB#_________________

SS#____ Relationship to Patient:
____

Signature of insured: ____

Dental History:

What would you like us to do today? ________________________________ Are you in dental discomfort today? ____ Former Dentist: __________________________________

Date of last Dental care: ________________________ Date of last x-rays:________________________________

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

Bad breath   Bleeding gums   Clicking or popping jaw   Grinding/clenching of teeth   Periodontal treatment   Sensitivity to cold/ hot or sweets______   Sensitivity when biting   Sores or growths in mouth

How often do you brush?______________________   How do you feel about the appearance of your teeth?____

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

Medical History

Physician's name____________________________________Phone______________________________________

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? ____

Any allergies to Drugs/Medications, Food, Latex Products Other: Please list_______________________________

____

Medical History Cont.

Have you ever had or 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		

Do you now or have you ever used tobacco? (circle) Yes No

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

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

Medications

Please list all current medication you are taking prescribed and Over-the-Counter:

_______________________________ ___________________________________

_______________________________ ___________________________________

_______________________________ ___________________________________

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____ Date_________________________

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