

AESTHETIC COMPREHENSIVE DENTISTRY

We are a health-centered dental practice, thus we are concerned with your total well being, not just your oral health. An essential part of our approach is a thorough health history. Please fill out the health questionnaire below completely-even if some of the questions may not seem relevant to your dental health. Thank You!

What are your hobbies or special interests? _____ How did you hear about our office? _____

E-mail _____

Full Name _____ Soc. Sec. No. _____ Date _____

Address _____ City _____ Zip _____

Date of Birth _____ Weight _____ Height _____ Single _____ Married _____ Widowed _____ Divorced _____ Age _____

Employer _____ Occupation _____

Home# _____ Work# _____ Cell# _____

EMERGENCY INFORMATION

1. Your physician's name _____
2. His/her phone number _____
3. Name of things allergic to (meds) _____
4. Medications currently taking _____

-Pursuant to VA Law 32.1-45.1-Any patient who exposes a health care provider or his employee/ agent to body fluid in a manner which may transmit the HIV, Hepatitis B or C virus is deemed to have consented to HIV, Hepatitis B & C testing and disclosure of the results to the person exposed. This deemed consent also applies to a health care provider who exposes a patient to body fluid in the above stated manner.

GENERAL HEALTH QUESTIONNAIRE

When was your last complete physical exam? _____

Are you being treated by a physician at this time? Yes No
For what? _____

Do you need to be premedicated? Yes No

Have you been tested for the HIV virus? Yes No

Have you ever had a blood transfusion? Yes No
Reason _____

Have you ever had any of the following?

Yes	No	
		Heart Disease
		Prosthesis
		Heart Transplant
		Heart Murmur/MVP
		Rheumatic Fever
		Hi/Low Blood Pressure
		Excessive Bleeding
		Diabetes or History of
		Hypoglycemia
		Hepatitis of Liver Disease
		Arthritis
		Venereal Disease
		Kidney Disease
		Epilepsy
		HIV Virus
		Asthma
		Tuberculosis
		Lung Disease
		Traveled outside U.S.
		Joint Surgery

Others (Please List) _____

Yes	No	
		History of Cancer
		Psychiatric Treatment or Nervous Disorders
		Glaucoma or Eye Problems
		Sinusitis
		Menopause
		Are You Pregnant
		Headaches, Migraines
		Back or Neck Pain
		Thyroid Problem
		Thyroid Surgery
		Stomach Problem
		Ulcers
		Gout
		AIDS
		Fainting or Blackouts
		Tranquilizers
		Muscle Relaxant
		Antidepressant
		Birth Control Pill
		Blood Thinner or use Aspirin daily
		Do you use Tobacco

DENTAL HISTORY

1. When did you have your last dental exam? _____

2. Where? _____ Doctor's Name _____

3. Have you had any problems with your teeth? Yes No

4. What Kind? _____

5. Teeth sensitive to sweet? Yes No Pressure? Yes No

6. Are they sensitive to hot? Yes No or cold? Yes No

7. Do your gums ever bleed? Yes No

8. How often do you brush? _____ Floss _____

9. Do you grind or crunch your teeth ever while awake or asleep?
 Yes No

12. Are you pleased with the appearance of your teeth? Yes No

13. What do you feel the condition of your mouth is?
 excellent good fair poor

14. Is there any treatment you would like us to discuss?

Medical History Review/DATE: _____

DATE: _____

DATE: _____

The information above is correct to the best of my knowledge. I give my consent to have the necessary treatment for my benefit (or my minor) only after it has been mutually approved.

Signature of Patient

Date

Signature of Responsible Party

Date