

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		Yes	No	
		Heart Disease			History of Cancer
		Prosthesis			Psychiatric Treatment or Nervous Disorders
		Heart Transplant			Glaucoma or Eye Problems
		Heart Murmur/MVP			Sinusitis
		Rheumatic Fever			Menopause
		Hi/Low Blood Pressure			Are You Pregnant
		Excessive Bleeding			Headaches, Migraines
		Diabetes or History of			Back or Neck Pain
		Hypoglycemia			Thyroid Problem
		Hepatitis of Liver Disease			Thyroid Surgery
		Arthritis			Stomach Problem
		Venereal Disease			Ulcers
		Kidney Disease			Gout
		Epilepsy			AIDS
		HIV Virus			Fainting or Blackouts
		Asthma			Tranquilizers
		Tuberculosis			Muscle Relaxant
		Lung Disease			Antidepressant
		Traveled outside U.S.			Birth Control Pill
		Joint Surgery			Blood Thinner or use Aspirin daily
		Others (Please List) _____			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