## *HEALTH HISTORY*

**Circle**

**1. Are you having pain and discomfort at this time?** _____ **Yes No**
**2. Do you feel nervous about having dental treatment?** _____ **Yes No**
**3. Have you ever had a bad experience in a dental office?** _____ **Yes No**
**4. Have you been a patient in the hospital during the past two years?** _____ **Yes No**
**5. Have you been under the care of a medical doctor during the past two years?** _____ **Yes No**

**Physicians Name** _____ **Phone #** _____

**Address** _____

**6. Have you taken any medicine or drugs in the last two years?** _____

**If yes, please list:** _____

_____

**7. Are you allergic or have you reacted adversely to any of the following medications? Please circle below** _____ **Yes No**

| | | | | |
|---|---|---|---|---|
| **Aspirin** | **Sulfa** | **Nitrous Oxide** | **Valium** | **Local Anesthetic (Novocaine or Xylocaine)** |
| **Darvon** | **Bleach** | **Erythromycin** | **Scopolamine** | **Sleeping Pills (Nembutal / Seconal)** |
| **Codeine** | **Latex** | **Tetracycline** | **Penicillin** | **Metals** |
| **Demerol** | **Percodan** | **Other Antibiotics** _____ | | |

**8. Are you allergic or have you reacted to any other medications or substance?** _____ **Yes No**

**If yes, please list:** _____

**9. Circle any of the following which you have had or have at present:**

| | | | |
|---|---|---|---|
| **Heart Failure** | **Anemia** | **Emphysema** | **AIDS/HIV Positive** |
| **Heart Disease or Attack** | **Stroke** | **Cough** | **Hepatitis A (infectious)** |
| **Angina Pectoris** | **Kidney Disease** | **Tuberculosis (TB)** | **Hepatitis B (serum)** |
| **High Blood Pressure** | **Ulcers** | **Asthma** | **Hepatitis C or Liver Disease** |
| **Heart Murmur** | **Hay Fever** | **Cortisone Medicine** | **Blood Transfusion** |
| **Rheumatic Fever** | **Sinus Trouble** | **Glaucoma** | **Chemical Dependency** |
| **Congenital Heart Lesions** | **Allergies or Hives** | **Pain in Jaw Joints** | **Hemophilia** |
| **Scarlet Fever** | **Diabetes** | **Cosmetic Surgery** | **Venereal Disease (Syphilis, Gonorrhea)** |
| **Artificial Heart Valve** | **Thyroid Disease** | **Blood Thinners** | **Cold Sores** |
| **Heart Pacemaker** | **Psychiatric Treatment** | **Fever Blisters** | **Chemotherapy (Cancer, Leukemia)** |
| **Heart Surgery** | **Sickle Cell Disease** | **Epilepsy or Seizures** | **X-ray or Cobalt Treatment** |
| **MVP (Mitral Valve Prolapse)** | **Arthritis** | **Bruise Easily** | **Fainting or Dizzy Spells** |
| **Artificial Joints (Hip, Knee)** | **Shingles** | **Rheumatism** | |

**10. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired?** _____ **Yes No**
**11. Have you lost or gained more than 10 pounds in the past year?** _____ **Yes No**
**12. Do you ever wake up from sleep short of breath?** _____ **Yes No**
**13. Are you on a special diet?** _____ **Yes No**
**14. Has your medical doctor ever said you have a tumor or cancer?** _____ **Yes No**
**15. Do you have any disease, condition or problem not listed?** _____ **Yes No**

**For Women only: Are you pregnant? Yes No Are you taking birth control pills? Yes No**

## *AUTHORIZATION, CONSENT and HIPAA ACKNOWLEDGEMENT*

**I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will we used by the dentist to help determine appropriate and healthful dental treatment. I authorize Doctor to take x-rays, study models, photographs or other diagnostic aids deemed appropriate by Doctor to make a through diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with me. I further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. If there is any change in my medical status, I will inform the dentist. I authorize my current insurance to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions and for the dentist to release all information necessary to secure the payment of benefits. I understand I am financially responsible for all charges whether or not paid by insurance. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. You may opt to receive a statement of your account balance, payable within 30 days of services rendered, however, you must provide a social security number. I further understand that a 22% finance charge will be added to any balance over 90 days. In the event of default, I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as my be required to effect collection of this note.**

**I have been informed of Critchfield Dental's privacy policies which are in accord with the HIPAA Act of 2003.**

**SIGNATURE:** _____ **DATE:** _____