HEALTH QUESTIONNAIRE

LifeTime Smiles of OC

These questions are for your benefit and assure that treatment will take into consideration your past and present health status.
Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care.
Please answer each question. Check the appropriate box and/or circle **YES or NO** where applicable. Example: Are you alive?........ (**YES**) **NO**

1. HISTORY

1. Are you in good health? .... **YES NO**
2. Have you lost or gained more than 10lb in the past year? .... **YES NO**
3. Date of last physical examination ________
4. Have you ever taken Fen-Phen, Redux, or Pondimen? .... **YES NO**
5. Are you now under the care of a physician? .... **YES NO**
   If so, what is the condition being treated? ________
6. Have you ever had any serious illness or operation? .... **YES NO**
   If so, what illness or operation? ________
7. Have you ever been hospitalized? .... **YES NO**
   If so, what was the problem? ________
8. Are you taking any medication? .... **YES NO**
   If so, what? ________ *What dosage?* ________
9. Are you using any recreational drugs (marijuana, cocaine, etc.) ? .... **YES NO**
   If so, what? ________
10. Have you ever been pre-medicated with antibiotics for your dental treatment? .... **YES NO**
11. Are you sensitive or allergic to any drugs?
    ❑ Penicillin; ❑ Tetracycline; ❑ Sulfa Drugs; ❑ Aspirin; ❑ Codeine; ❑ Other .... **YES NO**
    If Other, what drugs? ________
12. Do you have or had any of the following:
    (Please circle **'Y'** for Yes **'N'** for No - **answer all conditions**):

Y N Anemia	**Y N** Hemophilia	**Y N** Heart Murmur	**Y N** Tuberculosis (T.B.)	**Y N** Cortisone Medicine	**Y N** Heart Ailments or Attack
Y N Herpes	**Y N** Cold Sores	**Y N** Liver Disease	**Y N** Rheumatic Fever	**Y N** Allergies to Metals	**Y N** Prolapse Heart Valve
Y N Stroke	**Y N** Emphysema	**Y N** Blood Disease	**Y N** Blood Transfusion	**Y N** Excessive Bleeding	**Y N** Congenital Heart Lesions
Y N Ulcers	**Y N** Rheumatism	**Y N** Drug Addiction	**Y N** Join Replacement	**Y N** High Blood Pressure	**Y N** X-Ray or Colbolt Treatment
Y N Diabetes	**Y N** Chicken Pox	**Y N** Kidney Disease	**Y N** Nervous Disorders	**Y N** HIV Related Complex	**Y N** Fainting Spells
Y N Glaucoma	**Y N** Bruise Easily	**Y N** Stomach Ulcers	**Y N** Tumors or Growths	**Y N** Respiratory Disease	**Y N** Chemotherapy (Cancer, Leukemia)
Y N Arthritis	**Y N** Head Injuries	**Y N** Angina Perctoris	**Y N** Allergies or Hives	**Y N** Epilepsy or Seizures	**Y N** Radiation Treatment of any kind
Y N Latex Allergy	**Y N** Heart Failure	**Y N** Mental Disorder	**Y N** Pain in Jaw Joints	**Y N** Psychiatric Treatment	**Y N** Venereal Disease (Syphilis, Gonorrhea)
Y N Tonsillitis	**Y N** Scarlet Fever	**Y N** Cerebral Palsy	**Y N** Artificial Prosthesis	**Y N** Hepatitis or Jaundice	**Y N** Acquired Immune Deficiency Syndrome (AIDS)
Y N Asthma	**Y N** Sinus Trouble	**Y N** Thyroid Disease	**Y N** Sickle Cell Disease	**Y N** Difficulty in Swallowing	**Y N** TMJ (Temporomandibular Joint) Disorder
Y N Gerd/Reflux	**Y N** Persistent Fever	**Y N** Night Sweats	**Y N** Persistent Cough	**Y N** Blood in Sputum	**Y N** Other:

13. Do you wear a cardiac pacemaker, or have you had heart surgery? .... **YES NO**
14. Do you have any disease, condition or problem not listed that you think we should know about? .... **YES NO**
    If so, what? ________
15. Do you smoke? If so, how much? ____ ❑ Cigarettes; ❑ Cigars; ❑ Packs per day .... **YES NO**
16. (Women) Are you pregnant? If so, how many months? .... **YES NO**
17. (Women) Do you have any problems associated with your menstrual period? .... **YES NO**
18. (Women) Do you take birth control pills? .... **YES NO**

2. DENTAL HISTORY

1. Have you ever had a local anesthetic (Novocaine, etc.)? .... **YES NO**
2. Have you ever had any unfavorable reaction form a local anesthetic? .... **YES NO**
3. Have you had any serious trouble associated with any previous dental treatment? .... **YES NO**
   If so, explain? ________
4. How long since your last full mouth X-Rays? .... ___ **WEEKS** ___ **MONTHS** ___ **YEARS**
5. How long since your last dental treatment? .... ___ **WEEKS** ___ **MONTHS** ___ **YEARS**
6. Does dental treatment make you nervous? ❑ Slightly ❑ Moderately ❑ Extremely? ... **YES NO**
7. Would you desire to be pre-sedated? .... **YES NO**

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or if my medications change, I will, without fail, inform the doctor at my next appointment.

A DATE ________ **SIGNATURE** ________

B DATE ________ **SIGNATURE** ________
Changes in health since last visit (If no changes, please write 'None')
____

C DATE ________ **SIGNATURE** ________
Changes in health since last visit (If no changes, please write 'None')
____

D DATE ________ **SIGNATURE** ________
Changes in health since last visit (If no changes, please write 'None')
____

E DATE ________ **SIGNATURE** ________
Changes in health since last visit (If no changes, please write 'None')
____

F DATE ________ **SIGNATURE** ________
Changes in health since last visit (If no changes, please write 'None')
____

Health Questionnaire MUST be continually updated!

CONSENT FOR TREATMENT

I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form, to administer such anesthetics, analgesics, sedative, nitrous oxide sedation and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

All services are rendered and accepted under the terms and conditions printed on the reverse hereof:

SIGNED: ________ **DATE:** ________

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

RELATIONSHIP TO THE PATIENT:

PATIENT INFORMATION

LifeTime Smiles of OC

(This information is necessary for our files and will be considered CONFIDENTIAL)

Patient's Name ______________________ **Age** ________
LAST FIRST INITIAL

If patient is a minor, give name of parent or legal guardian: __________

Residence Address: ______________________
STREET CITY ZIP

Patient is: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed ❑ Minor

Responsible Party Name ______________ **Drivers License No.** ______________

Social Security No. ______________ Occupation ______________

Employed by ______________ How Long? ______________

Business Address ______________________
STREET CITY ZIP

Spouses Name ______________ Drivers License No. ______________

Employed by ______________ How Long? ______________

Business Address ______________________

Emergency Contact (nonresident) ______________ **Relationship** ________

Complete Address ______________________
STREET CITY ZIP

Name of Physician ______________________ ( ) ________
STREET CITY ZIP TELEPHONE

Former Dentist ______________________ ( ) ________
STREET CITY ZIP TELEPHONE

Patient's Birthday: ________ ❑ Male ❑ Female

Relationship: ______________

For how long? ________ ❑ Own ❑ Rent

Patient SS# ______________

Res. Phone ( ) ________

Cell Phone ( ) ________

Bus. Phone ( ) ________

Soc. Sec. No. ( ) ________

Occupation ________

Bus. Phone ( ) ________

Relationship ________

Day time Phone ( ) ________

Home Phone ( ) ________

Why are you changing dentists? ______________________

Purpose of Appointment ______________________

Is this office visit for Emergency Dental Care? ❑ **YES** ❑ **NO** If yes, explain: ______________

Who may we thank for referring you? ______________________

FINANCIAL INFORMATION

Person responsible for this account ______________ Relationship ______________

Address ______________________ ( ) ________
STREET CITY ZIP TELEPHONE

Preference of payment: ❑ Check ❑ Cash ❑ Visa/Mastercard

Name of dental insurance company (primary insurance) ______________________

SUBSCRIBER NAME BIRTHDAY RELATIONSHIP SOCIAL SECURITY NO.

NAME OF GROUP DENTAL PLAN GROUP NO PLAN NO. NAME OF UNION LOCAL

Name of dental insurance company (primary insurance) ______________________

SUBSCRIBER NAME BIRTHDAY RELATIONSHIP SOCIAL SECURITY NO.

NAME OF GROUP DENTAL PLAN GROUP NO PLAN NO. NAME OF UNION LOCAL

TERMS & CONDITIONS

As a condition of treatment by this office, I understand financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.
All emergency dental services, or any dental service performed without prior arrangements, must be paid for in cash as the time services are performed.
I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office can not render services on the assumption that charges will be paid by and insurance company.
Assignment of insurance: I hereby authorize my insurance company to pay directly to my dentist benefits accruing to me under my policy.
A service charge of 1.5% per month (18% per annum) (but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within 60 days of treatment date.
I understand that the fee estimate for this dental case can only be extended for a period of six months from the date of the patient examination.
In consideration of the professional services rendered to me, or at my request, by the Doctor and/or his staff, I agree to pay, therefore, the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing of credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to by me, in writing, within the time for payment thereof. Additionally. I agree that a waiver for any breach of any term or conditions hereunder shall not constitute a waiver of any further term of condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorneys and/or collection fees.
I grant my permission to you, or your assigns, to telephone me at home or my work to discuss related to this form.
I have read the above conditions of treatment and agree to their content.

SIGNED: ______________________ **DATE:** ______________________

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

(OVER)