

S. M. Griffin, DDS

**Patient Information
Confidential**

Name _____ Date _____
Address _____
City, State, Zip _____
Home # _____ Work # _____ Cell # _____
Pager # _____ Fax # _____ E-Mail _____
Date of Birth _____ Social Security # _____
Are you: Minor _____ Single _____ Married _____ Separated _____ Divorced _____ Widowed _____
Your Employer _____ Occupation _____
Business Address _____ City, State, Zip _____
Name of School _____ Full Time Student _____ Part Time Student _____
Spouse or Parent's Name _____ Work Number _____
Person to notify in case of emergency _____ Phone # _____
Reason for today's dental appointment _____

Who may we thank for referring you to us? _____

Responsible Party

Name of person responsible for this account? _____
Relationship to patient _____ Telephone Number _____
Address _____ City, State, Zip _____
Name of Employer _____ Phone # _____

Insurance Information

Name of Insured _____ Relationship _____
Birth Date _____ Soc Sec # _____ ID# _____
Name of Employer _____ Work # _____
Address _____ City, State, Zip _____
Insurance Co _____ Phone # _____
Insurance Address _____ City, State, Zip _____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? ___ Yes ___ No - If yes please complete

Name of Insured _____ Relationship _____
Birth Date _____ Soc Sec # _____ ID# _____
Insured's Address _____ City, State, Zip _____
Name of Employer _____ Work # _____
Address _____ City, State, Zip _____
Insurance Co _____ Phone # _____
Insurance Address _____ City, State, Zip _____

Patient Signature _____ Date _____

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HEALTH QUESTIONNAIRE

| | | | |
|-----------------------|-----------------------|--------------------|---------------------------|
| <u>Today's Date</u> | <u>Patient's Name</u> | <u>Birthdate</u> | <u>Social Security #</u> |
| <u>Street Address</u> | <u>City</u> | <u>Zip</u> | <u>Driver's License #</u> |
| <u>Home Phone #</u> | <u>Work Number #</u> | <u>Cell/Pager#</u> | <u>e-mail address</u> |

Name of person completing form (if different from patient) and relation to patient: _____

Please answer the following questions to the best of your ability, realizing that true and accurate answers are important to the delivery of quality care. All information you provide will be kept confidential.

****PLEASE ANSWER YES (Y) OR NO (N) FOR EACH INDIVIDUAL QUESTION.**

1. Are you in good health? Y N
2. Has there been any change in your general health in the past year? Y N
3. Date of last check up by physician? _____
4. Are you currently under a physician's care? Y N
 If so, what for? _____
 Treating Physician's Name: _____ Phone Number: _____
5. Have you had any serious illness, operations, or hospitalizations? Y N
 If so, describe and give approximate dates: _____
6. Have you ever had intravenous sedation or general anesthesia? Y N
 Were there any adverse effects? Y N
7. Do you generally tolerate dental treatment well? Y N
8. DO YOU HAVE OR HAVE YOU EVER HAD:
 - A. Heart Disease that was detected at birth? Y N
 - B. Rheumatic fever or Rheumatic heart disease? Y N
 - C. Cardiovascular Disease (chest pain, heart trouble, heart attack, coronary heart disease, high blood Pressure, stroke, palpitations, heart surgery, angioplasty, pacemaker)? Y N
 - D. Lung Disease (asthma, emphysema, chronic cough, bronchitis, pneumonia, TB, shortness of breath, Severe cough)? Y N
 - E. Neurological Disorders (seizure, epilepsy, fainting, dizziness, nervous disorder)? Y N
 - F. Blood Disease (bleeding disorder, anemia, blood transfusion, do you bruise easily)? Y N
 - G. Liver Disease (jaundice, hepatitis)? Y N
 - H. Kidney Disease? Y N
 - I. Diabetes? Y N
 - J. Thyroid Disease (hypothyroidism, tumor)? Y N
 - K. Arthritis? (which joints?) Y N
 - L. Stomach ulcers or Intestinal problems? Y N
 - M. Glaucoma? Y N
 - N. Frequent or recurring mouth sores? Y N
 - O. Implants/artificial joints anywhere in your body/ (heart valve, hip, knee)? Y N
 - P. Radiation (x-ray treatment for cancer) in head and neck region? Y N
 - Q. Noises in jaw joint, pain near ear when chewing, do you grind or clench your teeth? Y N
 - R. Sinus or nasal problems? Y N
 - S. Any disease, drug or transplant operation that has depressed your immune system? Y N
 - T. Recurrent infections of any kind? Y N

Please continue on the next page

9. ARE YOU TAKING OR USING ANY OF THE FOLLOWING?

- | | | |
|---|---|---|
| A. Antibiotics? | Y | N |
| B. Anticoagulants (blood thinners)? | Y | N |
| C. Thyroid medications? | Y | N |
| D. Antihistamines, decongestants? | Y | N |
| E. High Blood Pressure or Heart medications? | Y | N |
| F. Steroids? | Y | N |
| G. Tranquilizers, Antidepressants? | Y | N |
| H. Stomach or GI medications (antacids, etc.)? | Y | N |
| I. Cholesterol reducing drugs? | Y | N |
| J. Aspirin, Ibuprophen, NSAIDS or anti-inflammatory drugs, narcotics, opiates, or other pain relievers? | Y | N |
| K. Weight reduction pills or diet aids (over the counter or "natural" products..) | Y | N |
| L. Vitamins, natural remedies (ginko, biloba, ephedra, ginseng, etc.) or other supplements? | Y | N |
| M. Marijuana, cocaine or other "recreational" drugs? | Y | N |
| N. Any other regular medications, pills, supplements or drugs? | Y | N |
| O. Are you currently or have you taken any type of bisphosphonates?..... | Y | N |
| Ex: Aredia, Zometa, Didronel, Actonel, Skelid, Fosamax, Boniva, etc..... | Y | N |

PLEASE LIST ALL CURRENT MEDICATIONS HERE: _____

10. ARE YOU ALLERGIC OR HAD A BAD REACTION FROM:

- | | | |
|---|---|---|
| A. Local anesthetic (Novocain-like drugs)? | Y | N |
| B. Penicillin, Amoxicillin, Cephalosporin's? | Y | N |
| C. Other Antibiotics? | Y | N |
| D. Barbiturates, sedatives? | Y | N |
| E. Aspirin, Ibuprophen, NSAIDS, or other pain medications? | Y | N |
| F. Codeine or other narcotics or opioids? | Y | N |
| G. Latex? | Y | N |
| H. Other allergies or reactions? | Y | N |
| Please list: _____ | | |
| 11. Do you have hay fever, frequent skin rashes, etc? | Y | N |
| 12. Do you use alcohol? How much per day? _____ | Y | N |
| 13. Do you smoke? | Y | N |
| What product and how many per day? _____ For how long? _____ | | |
| 14. Do you spit tobacco? | Y | N |
| For how long? _____ | | |
| 15. Are you, or have you been, in a drug or alcohol recovery program? | Y | N |
| 16. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? | Y | N |
| 17. Do you wish to talk to the doctor privately about anything? | Y | N |
| 18. Any additional comments? _____ | | |
| 19. Women | | |
| A. Are you taking birth control pills? | Y | N |
| B. Are you pregnant, trying to become pregnant or <u>any chance</u> you might be pregnant? | Y | N |
| C. Are you BREAST FEEDING | Y | N |
| D. Are you taking hormonal replacement? | Y | N |

*May we leave messages on your home, work or cell telephone numbers Y N

I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.

Date

Signature of person completing Health History