DEDHAM FAMILY DENTAL

Patient Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Telephone # _____ Work Telephone # _____
Date of Birth: _____ Soc. Security # _____
Occupation: _____ Employer: _____
Dental Insurance: _____ Group # _____
I.D. # _____
Subscriber's Name: _____
Relationship to Sub.: _____

_ _

Health Questionnaire (Place an X on the appropriate line)

	YES	NO
1. Do you have now or have you ever had any major medical problems?	_____	_____
2. Are you now or have you recently been taking any drugs or medicine?	_____	_____
IF YES, PLEASE LIST: _____		
3. Are you allergic or sensitive to any drugs, foods, or medicine?	_____	_____
IF YES, PLEASE LIST: _____		
4. Do you have any difficulty with bleeding or healing from a cut, wound, or tooth extraction?	_____	_____
5. Do you have frequent nosebleeds or bruise easily?	_____	_____
6. Are you now or have you recently been under the care of a physician?	_____	_____
NAME OF PHYSICIAN:_____ ADDRESS:_____		
7. When was your last physical examination?_____		
8. Have you recently experienced a rapid loss or gain in weight or appetite?	_____	_____
9. WOMEN: Are you currently pregnant?	_____	_____
Number of months: _____ Are you currently taking birth control pills?	_____	_____

10. Do you have, or have you ever had any of the following? (Place an X on the appropriate lines)

_____ Rheumatic fever/heart disease
_____ Heart Murmur
_____ Heart Disease
_____ Heart attack
_____ Angina or chest pain
_____ Hypertension/high blood pressure
_____ Stroke
_____ Anemia (thin blood or other blood disease)
_____ Lung problems (TB, pneumonia, asthma)
_____ Liver problems (hepatitis, Jaundice)
_____ Stomach or intestinal problems (ulcer)
_____ Kidney problems (infections, etc.)
_____ VD (syphilis, gonorrhea)
_____AIDS,HIV

_____ Asthma or hay fever
_____ Allergies-food or drug
_____ Nervous disorders
_____ Convulsions (seizure)
_____ Epilepsy
_____ Diabetes
_____ Fainting/dizziness
_____ Inflammatory arthritis
_____ Tumors or growths
_____ Sinus problems
_____ Skin disease
_____ Thyroid problems
_____ Other

I certify that this health history is correct and I consent for the patient named above to receive all necessary treatment. I understand that the proposed treatment will be explained by the dental personnel.
SIGNATURE: (PATIENT, PARENT, GUARDIAN) _____
DATE: _____

REVIEWED BY: _____ D.M.D.