

CONEJO DENTAL GROUP

PATIENT INFORMATION

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

Date _____

Whom may we thank for referring you _____

Patient's Name _____ Age _____ Birthday _____ Male Female
Last First MI

Address _____ Apt # _____
Street

City _____ Zip _____

Home Phone _____ Business Phone _____ Ext _____

Email Address _____

Patient is: Married Single Divorced Separated Widowed Minor

Driver's License No _____ Social Security No _____

Employed By _____ Occupation _____

Business Address _____

Spouse Name _____ Birthday _____ Social Security No _____

Spouse Employed By _____ Phone _____

Occupation _____

Name of nearest relative not living with you _____

Address _____ Phone No _____

If patient is a minor:

Father's Name _____ Social Security No _____
Last First MI

Address _____ Phone _____

Mother's Name _____ Social Security No _____
Last First MI

Address _____ Phone _____

School _____

CONEJO DENTAL GROUP HEALTH QUESTIONNAIRE

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.

Physicians Name _____ Address _____ Phone _____

MEDICAL HISTORY Please answer each question and check the appropriate box **Yes or No**

1. Are you in good health?..... Yes No
2. Date of last medical examination _____
3. Are you now under the care of a physician?..... Yes No
If so, what is the condition being treated? _____
4. Have you ever had any serious illness or operation?..... Yes No
If so, explain? _____
5. Have you ever been hospitalized? Yes No
If so, explain? _____
6. Are you taking medicine?..... Yes No
If so, what? _____
7. Are you taking any recreational drugs (marijuana, cocaine, etc)?..... Yes No
If so, what? _____
8. Are you sensitive or allergic to any drugs? Penicillin Tetracycline Sulfa Drugs Aspirin
 Codeine Other _____
9. **Do you have a Heart Murmur or Mitral Valve Prolapse?**..... Yes No
10. **Do you need to be pre-medicated for dental treatment ?**..... Yes No
11. Do you have or have you ever had any of the following?

AIDS/HIV+/ARC	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tuberculosis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Nervous Disorders	Yes <input type="checkbox"/> No <input type="checkbox"/>
Anemia	Yes <input type="checkbox"/> No <input type="checkbox"/>	Emphysema	Yes <input type="checkbox"/> No <input type="checkbox"/>	Mental Disorder	Yes <input type="checkbox"/> No <input type="checkbox"/>
Sickle Cell Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Respiratory Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Epilepsy or Seizures	Yes <input type="checkbox"/> No <input type="checkbox"/>
Hepatitis or Jaundice	Yes <input type="checkbox"/> No <input type="checkbox"/>	Asthma	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tonsillitis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Hemophilia	Yes <input type="checkbox"/> No <input type="checkbox"/>	Sinus Trouble	Yes <input type="checkbox"/> No <input type="checkbox"/>	Difficulty Swallowing	Yes <input type="checkbox"/> No <input type="checkbox"/>
Bruise Easily	Yes <input type="checkbox"/> No <input type="checkbox"/>	Chicken Pox	Yes <input type="checkbox"/> No <input type="checkbox"/>	Allergies or Hives	Yes <input type="checkbox"/> No <input type="checkbox"/>
Blood Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Cold Sores	Yes <input type="checkbox"/> No <input type="checkbox"/>	Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>
Excessive Bleeding	Yes <input type="checkbox"/> No <input type="checkbox"/>	Herpes	Yes <input type="checkbox"/> No <input type="checkbox"/>	Kidney Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Other Blood Transfusion	Yes <input type="checkbox"/> No <input type="checkbox"/>	Venereal Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Liver Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Heart Failure	Yes <input type="checkbox"/> No <input type="checkbox"/>	Joint Replacement	Yes <input type="checkbox"/> No <input type="checkbox"/>	Thyroid Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Congenital Heart Defect	Yes <input type="checkbox"/> No <input type="checkbox"/>	TMJ Disorder	Yes <input type="checkbox"/> No <input type="checkbox"/>	Glaucoma	Yes <input type="checkbox"/> No <input type="checkbox"/>
Scarlet Fever	Yes <input type="checkbox"/> No <input type="checkbox"/>	Cerebral Palsy	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tumors or Growths	Yes <input type="checkbox"/> No <input type="checkbox"/>
Rheumatic Fever	Yes <input type="checkbox"/> No <input type="checkbox"/>	Artificial Prosthesis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Ulcers	Yes <input type="checkbox"/> No <input type="checkbox"/>
Heart Attack	Yes <input type="checkbox"/> No <input type="checkbox"/>	Rheumatism	Yes <input type="checkbox"/> No <input type="checkbox"/>	Head Injuries	Yes <input type="checkbox"/> No <input type="checkbox"/>
Angina Pectoris	Yes <input type="checkbox"/> No <input type="checkbox"/>	Arthritis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Radiation Treatment	Yes <input type="checkbox"/> No <input type="checkbox"/>
Phen-fen / Redux	Yes <input type="checkbox"/> No <input type="checkbox"/>	Cancer/Leukemia	Yes <input type="checkbox"/> No <input type="checkbox"/>	Drug Addiction	Yes <input type="checkbox"/> No <input type="checkbox"/>
High Blood Press	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>	Other/ Not Listed	Yes <input type="checkbox"/> No <input type="checkbox"/>
Stroke	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

12. Do you wear a cardiac pacemaker, or have you had heart surgery?..... Yes No
13. Do you have any disease, condition or problem not listed Yes No
If so, what? _____
14. Do you smoke?..... Yes No
If so, how much? _____
15. (Women) Are you pregnant?..... Yes No
If so, how many months? _____ Due Date _____

16. (Women) Do you take birth control pills? Yes No

Patient Name _____

DENTAL HISTORY

- 1. What is the purpose of your appointment? _____
- 2. Are you having any pain? Yes No
If **Yes**, is the area sensitive to heat, cold, sweets, or biting pressure _____
- 3. Do your gums bleed easily? Yes No
- 4. Do you have a bad taste in your mouth? Yes No
- 5. Do you have offensive breath odor? Yes No
- 6. Have you been treated for gum disease? Yes No
- 7. How many times a **WEEK** do you floss your teeth? _____
- 8. How many times a **DAY** do you brush? _____
- 9. What other oral hygiene aids do you use? _____
- 10. Do you grind your teeth or have any pain in the joint of your jaw? Yes No
- 11. Are you satisfied with the appearance and color of your teeth? Yes No
- 12. Do you snore or have a sleeping disorder? Yes No
- 13. Does dental treatment make you nervous? Yes No
 Slightly Moderately Extremely
- 14. Do you have any other concerns regarding your teeth and gums? Yes No
Explain _____
- 15. Have you ever had any unfavorable reaction from a local anesthetic? Yes No
- 16. Have you had any serious problems associated with previous dental treatment? Yes No
- 17. How long since your last full mouth X-Rays? Months Years
- 18. How long since your last dental treatment? Months Years
- 19. Have you ever been premedicated with antibiotics for dental treatment? Yes No

PREVIOUS DENTIST

Name _____
 Address _____
 City _____ State _____ Zip _____
 Phone _____

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.

Signed _____ Date _____ Doctor Signed _____ Date _____

CONSENT FOR TREATMENT: I understand that the doctor will inform me of any necessary treatment prior to starting treatment. In the event that work is required I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on the Health Questionnaire form, to administer such analgesics, sedatives, nitrous oxide 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 to be rendered are accepted under the terms and conditions printed:

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.

Patient Name _____

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? Yes No

What medication do you take?

1. _____
2. _____
3. _____
4. _____

Date Signature

Date Doctor's Signature

MEDICAL HISTORY UPDATE

Has there been any changes in your health since your last dental appointment? Yes No

What medication do you take?

1. _____
2. _____
3. _____
4. _____

Date Signature

Date Doctor's Signature

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? Yes No

What medication do you take?

5. _____
6. _____
7. _____
8. _____

Date Signature

Date Doctor's Signature

MEDICAL HISTORY UPDATE

Has there been any changes in your health since your last dental appointment? Yes No

What medication do you take?

1. _____
2. _____
3. _____
4. _____

Date Signature

Date Doctor's Signature

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? Yes No

What medication do you take?

9. _____
10. _____
11. _____
12. _____

Date Signature

MEDICAL HISTORY UPDATE

Has there been any changes in your health since your last dental appointment? Yes No

What medication do you take?

1. _____
2. _____
3. _____
4. _____

Date Signature

Date

Doctor's Signature

Date

Doctor's Signature
