RELATIONSHIP TO PATIENT OR INSURED				SEX	
SELF	SPOUSE	CHILD	OTHER	M	F

HEALTH QUESTIONAIRE FOR DENTAL PATIENTS

Patient Name ______________________________ Patient Date of Birth ____/____/____

Patient Street Address ______________________________ City,State,Zip Code ______________________

Patient Home Phone ____________________ Cell ____________________ Work ____________________

Patient Social Security No. ____________________ **Email Address** ______________________________

PRIMARY INSURANCE- DENTAL

Name of Insured ______________________ Insured's ID# ______________ Group# __________

Insured's Street Address ______________________________ City,State,Zip Code ______________________

Insured's SS# ______________ Insured's Date of Birth __/__/__ Insured's Telephone# ______________

Company Where Employed ____________________ Co.Address & Phone ______________________________

FOR PRIVATE-PAY PATIENTS

Company Where Employed ____________________ Co.Address & Phone ______________________________

Spouse's or Close Relative's Name and Telephone # ______________________________

PLEASE CIRCLE "YES" OR "NO" TO EACH OF THE FOLLOWING:

1.HAVE YOU BEEN ILL RECENTLY? YES NO

2.ARE YOU UNDER THE CARE OF A PHYSICIAN FOR ANY CONDITION? YES NO

3.DO YOU SMOKE? YES NO

(IF YES GIVE NAME, ADDRESS, AND TELEPHONE NO. OF PHYSICIAN) ______________________________

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? PLEASE CIRCLE "YES" OR "NO"

1.RHEUMATIC FEVER	YES	NO	7. RHEUMATIC HEART DISEASE	YES	NO
2.AIDS SYNDROME /HIV	YES	NO	8.HEART ATTACK OR DISEASE	YES	NO
3.STROKE	YES	NO	9.HIGH BLOOD PRESSURE	YES	NO
4.DIABETES	YES	NO	10.HEPATITIS A B C	YES	NO
5.EPILEPSY	YES	NO	11.TUBERCULOSIS	YES	NO
6.ASTHMA	YES	NO	12.VENERAL DISEASE /BAD BLOOD	YES	NO

ARE YOU PREGNANT? YES NO

DOCTOR FOR PREGNANCY ____________________

IF YES HOW MANY MONTHS __________

DOCTOR'S TELEPHONE ____________________

ARE YOU TAKING ANY MEDICINES OR DRUGS NOW? YES NO

(IF YES PLEASE NAME MEDICATIONS BELOW)

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NOTE: IT IS VERY IMPORTANT FOR US TO KNOW IF YOU ARE TAKING TRANQUILIZERS, PHENOBARBITAL DILANTIN, ANY MEDICINE TO PREVENT BLOOD CLOTS, CORTISONE, INSULIN, BLOOD PRESSURE OR HEART MEDICINE.

13 .HAVE YOU EVER HAD AN ALLERGIC REACTION TO PENICILLIN, OTHER MEDICINES, A LOCAL ANESTHETIC, OR ANY FOOD?
YES NO **(IF YES PLEASE NAME BELOW)**

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14. HAVE YOU EVER BLED UNUSUALLY LONG OR HEAVILY AFTER A TOOTH EXTRACTION OF INJURY? YES NO

15. HAVE YOU EVER HAD TREATMENT FOR A TUMOR OR GROWTH? YES NO

16. HAVE YOU TAKEN ANY CORTISONE MEDICINE WITHIN THE LAST 6 MONTHS? YES NO

17. DO YOU HAVE ANY SORE IN YOUR MOUTH OR ANYWHERE ELSE THAT HAS BEEN THERE FOR MORE THAN 10 DAYS OR LONGER? YES NO

I AGREE TO BE RESPONSIBLE TO PAY FOR ALL DENTAL SERVICES PROVIDED BY WEST BROADWAY DENTAL P.A. TO ME (OR MY DEPENDENT NAMED ABOVE). WEST BROADWAY DENTAL P.A. MAY SUBMIT CLAIMS FOR PAYMENT OF THE SERVICES IT RENDERS TO ME (OR MY DEPENDENT NAMED ABOVE) TO MY DENTAL INSURANCE COMPANY. IF MY DENTAL INSURANCE COMPANY DOES NOT PAY THE FULL AMOUNT AS CLAIMED WITHIN 90 DAYS, I AGREE TO PAY PROMPTLY THE FULL BALANCE DUE. I ALSO AGREE THAT I HAVE READ AND UNDERSTOOD EACH QUESTION CONTAINED ON THIS FORM, AND HAVE ANSWERED EACH QUESTION COMPLETELY AND TRUTHFULLY TO THE BEST OF MY ABILITY.

______________________________ ______________________

SIGNATURE OF PATIENT, PARENT OR GUARDIAN **DATE**

WEST BROADWAY DENTAL P.A.

ACKNOWLDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, ____, have seen a notice of this office's Privacy Practices.

____
Please Print Name

____
Signature

____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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