WELCOME TO OUR OFFICE

We are a health-centered dental practice, thus we are concerned with your total well-being, not just your oral health. An essential part of our approach is a thorough health history. Please fill out the health questionnaire below completely – even if some of the questions may not seem relevant to your dental health. Thank You!

Do you have or have you ever had any of the following:

Heart Attack or Heart Trouble	YES/NO	Lung problems, Tuberculosis	YES/NO
Heart Murmur	YES/NO	Epilepsy, Seizures	YES/NO
Mitral Valve Prolapse	YES/NO	Blood Transfusions	YES/NO
Rheumatic Fever	YES/NO	Facial or Head Injuries	YES/NO
Congenital Heart Defects	YES/NO	Radiation Treatments	YES/NO
Have you taken Fen-Phen	YES/NO	Malignancies, Cancer	YES/NO
Artificial or Replaced Heart Valves	YES/NO	Stroke	YES/NO
Hip or Knee Replacement	YES/NO	Anemia, Blood Disorder	YES/NO
Any Prosthetic Joints	YES/NO	Excessive Bleeding	YES/NO
HIV Positive (AIDS)	YES/NO	Fainting, Blackouts	YES/NO
Hypoglycemia, Diabetes	YES/NO	Nervous Disorders	YES/NO
STD	YES/NO	Headaches, Migraines	YES/NO
Hay Fever, Asthma, Allergies	YES/NO	Kidney Problems	YES/NO
High Blood Pressure	YES/NO	Glaucoma, Eye Problems	YES/NO
Circulatory Problems	YES/NO	Ulcers, Digestive problems	YES/NO
Hepatitis, Jaundice	YES/NO	Are you pregnant now?	YES/NO
		Other ____________________	

Physician's Name ____

Have you seen your physician or been hospitalized in the last two years?

If yes, please explain____

____

Have you had unfavorable reactions to any of the following? (Please circle)

Aspirin   Codeine   Anesthetics   Novocaine   Sedatives
Penicillin (Antibiotics)   Other Drugs ____________________

Please list any drugs currently being taken:

____

____

Have you noticed any of the following?

Teeth tender to chew on	YES/NO	Recurring sore in or around the mouth	YES/NO
Discomfort in face, head, neck	YES/NO	Jaw clicking or popping	YES/NO
Food caught between teeth	YES/NO	Sensitivity to hot or cold	YES/NO
Bleeding or sore gums	YES/NO	Swelling, lumps in mouth	YES/NO
Sensitivity to sweets	YES/NO		

Have you had any problems with previous dental treatment?____________________

____

The information above is correct to the best of my knowledge. I give my consent to have the necessary treatment recommended for my benefit (or my minor) only after it has been mutually approved. Should this information change, it is my responsibility to bring it to the attention of this office.

Date ____________________ Signature ____________________

Patient Information

Patient Last Name: ______________________ **First Name:** ____________________ **M.I.** _______

Patient Address Line 1: ____

Patient Address Line 2 (Apt#, Lot#, Suite): ______________________________

City: ____ State: _________ Zip: ___________/_______

Preferred Name (Nickname): ____________________________

Guarantor (Person responsible for paying bill): ______________________________________

Whom may we thank for referring you to our office?: ____

Employer Name & Address: ____

____

Home Phone: ______________________________ **Work Phone:** ______________________________

Mobile Phone: ______________________________ **Social Security #:** ______________________________

Birthday: ______________________________ **Gender: Male** _______ **Female** _______

Driver's License #: ___________________________

Today's Date (Consent): ______________________

INSURANCE ❑ Yes ❑ No

Employee Name ____

Social Security # __________________________________

Date of Birth _______________________________

I understand I will be informed of all treatment recommended by Dr. Langdon and consent to all treatment performed in this office.

I will allow Dr. Langdon to photograph and use for educational purposes any aspect of my dental conditions or treatment procedures, and further will allow him permission to discuss my conditions with my physician and to request medical information from him.

I understand that I am responsible for all costs which my insurance company may not pay at time of services rendered.

To the best of my knowledge, all of the preceding answers are true and correct.

Signature of Patient
Parent, or Guardian ____ Date ____________________________