ALLEGANY
DENTAL CARE

HEALTH HISTORY QUESTIONNAIRE

Patient Name ____________________ Date of Birth ____________
Account Number ____________

Circle

1. When did you last see a dentist? ____________
2. Are you having any pain or discomfort at this time? .... Y / N
3. Are you happy with the appearance of your smile? .... Y / N
4. Have you ever experienced a sensitivity to Latex? .... Y / N
5. Do you smoke or use smokeless tobacco? .... Y / N
6. Do you have any specific dental concerns? .... Y / N
   If yes, please explain ____________________
7. Are you presently being treated by a physician? .... Y / N
   If yes, please explain ____________________
   Physician's Name ____________________
   Physician's Phone Number (______) ____________
8. Are you presently taking any prescription or non-prescription medications? .... Y / N
   If yes, please list medications ____________________
9. Are you allergic to, or have you ever had an allergic reaction to any medications? (Penicillin, etc.) .... Y / N
   If yes, please explain ____________________
10. Do you have any heart conditions we should be aware of? .... Y / N
    (Murmur, Angina, Rheumatic Fever, High Blood Pressure, Surgeries, etc.)
    If yes, please explain ____________________
11. Have you ever had, or do you presently have:

Artificial Joints	Y / N	Diabetes	Y / N
TMJ Disorder	Y / N	Hepatitis	Y / N
Drug/Alcohol Dependency	Y / N	Thyroid Disorder	Y / N
Radiation/Chemotherapy Treatment	Y / N	HIV / AIDS	Y / N
		Asthma	Y / N

12. Is there any other information you would like us to know? .... Y / N
13. Are you taking Fosamax? .... Y / N
14. **Women Only:**
    Are you currently pregnant? .... Y / N
    Are you presently taking Birth Control? .... Y / N

Please complete other side

Form HHQ 10/03

MEDICAL HEALTH HISTORY ACKNOWLEDGEMENT AND CONSENT TO PROCEED

I certify that the answers to the medical/health questions are correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of, and agree to notify the dentist of, any changes at any subsequent appointment.

I authorize Allegany Dental Care, P.A. to perform those procedures deemed necessary or advisable to maintain my dental health, or that of my minor child or individual for which I have responsibility. I understand that such procedures will be discussed with me in advance of treatment, and that I will have the opportunity to ask questions about planned treatment.

Signature ______________________________ Date ______________
(Patient, legal guardian or authorized agent of patient)

Doctor's Signature ______________________________ Date ______________

UPDATE INFORMATION

FOR OFFICE USE ONLY

Please do not write below this line

Have there been any changes to your medical condition or medications? .... Y / N

If yes, please explain ______________________________

____

Signature ______________________________ Date ______________
(Patient, legal guardian or authorized agent of patient)

Doctor's Signature ______________________________ Date ______________

Have there been any changes to your medical condition or medications? .... Y / N

If yes, please explain ______________________________

____

Signature ______________________________ Date ______________
(Patient, legal guardian or authorized agent of patient)

Doctor's Signature ______________________________ Date ______________

Have there been any changes to your medical condition or medications? .... Y / N

If yes, please explain ______________________________

____

Signature ______________________________ Date ______________
(Patient, legal guardian or authorized agent of patient)

Doctor's Signature ______________________________ Date ______________