

It is important that I know your medical and dental history. These facts have a direct bearing on your dental health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

## HEALTH HISTORY and REGISTRATION

Patient name \_\_\_\_\_ (Nick name) \_\_\_\_\_ Birth date \_\_\_\_\_  
Home address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Occupation \_\_\_\_\_ Home phone \_\_\_\_\_ Email \_\_\_\_\_  
Your employer \_\_\_\_\_ Work phone \_\_\_\_\_ Cell/Pager \_\_\_\_\_  
Spouse name \_\_\_\_\_ Spouse employer \_\_\_\_\_ Work phone \_\_\_\_\_  
IF PATIENT IS A MINOR-  
Names: Mother \_\_\_\_\_ Father \_\_\_\_\_  
Work phone mother \_\_\_\_\_ Father \_\_\_\_\_

**Who may we thank for referring you to our office?** \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Physician's name \_\_\_\_\_ Phone \_\_\_\_\_  
General health status \_\_\_\_\_ Date last physical exam \_\_\_\_\_  
Current health problems \_\_\_\_\_  
Medications currently being taken \_\_\_\_\_  
Are you pregnant? \_\_\_ Yes ( \_\_\_ months) \_\_\_ No Do you smoke? \_\_\_ Yes \_\_\_ No

### CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR PRESENTLY HAVE:

Heart Disease or Attack	A.I.D.S./ A.R.C. / HIV Pos	Allergies or Hives
Angina Pectoris	Hepatitis Type _____	Diabetes
High Blood Pressure	Liver Disease	Thyroid Disease
Rheumatic Fever	Blood Transfusion	Arthritis
Congenital Heart Lesions	Drug Addiction	Cortisone Medication
Mitral Valve Prolapse	Bleeding Problems	Hypoglycemia
Artificial Heart Disease	Epilepsy or Seizures	Hyperglycemia
Pacemaker	Glaucoma	Prostate Problems
Heart Surgery	Bruise Easily	Contact Lenses
Heart Murmur	Emphysema	Headaches
Anemia	Kidney Trouble	Pain in Jaw Joints
Stroke		Ulcers

### ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

Aspirin      Local anesthesia      Erythromycin      Nitrous oxide      Codeine      Penicillin  
What other medications or substances are you allergic to? \_\_\_\_\_

Is there any other Medical or Dental information that you feel I should know about?

Consent: The undersigned hereby authorizes MAURY HAFERNIK, D.D.S. ("Doctor") and/or his staff to take x-rays, models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's needs. I also authorize Doctor to perform any and all forms of treatment and therapy that may be indicated. I also understand that the use of local anesthetic agents embodies certain risk.

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

Doctor Signature \_\_\_\_\_