Date ___________

Drs. Polack and Olano, PC

HEALTH QUESTIONNAIRE

Patient's Full Name ___________ **Phone** ___________

Name you preferred to be called ___________

Home Address ___________ **City** ___________ **State** ______ **Zip** ___________

Occupation ___________ **Employed By** ___________ **How Long** ________

Business Address ___________ **City** ___________ **State** ______ **Zip** ___________ **Phone** ___________

Patient's Physician ___________ **How Long** ___________

Date of Birth ___________ **Hgt** ______ **Wgt** ______ **Male** ____ **Female** ____ **Single** ____ **Married** ____ **Divorced** ____

SS No. ___________

Whom may we thank for your referral/How did you hear about us? ___________

Spouse or Parent (if minor) ___________

Insurance Information

Insurance Subscriber's Full Name ___________ **Phone** ___________

SS No. ___________ **Date of Birth** ___________

Relationship to Patient: **Self** ______ **Spouse** ______ **Parent** ______

Occupation ___________ **Employed By** ___________ **How Long** ________

Business Address ___________ **City** ___________ **State** ______ **Zip** ___________ **Phone** ___________

Dental Insurance Carrier ___________ **Subscriber's ID Number** ___________

Address ___________

Group No. ___________ **Group Plan Name** ___________

Dental History

1. When did you have your last dental examination? ___________ Dentist ___________
   Was restorative treatment recommended? ___________ What treatment was recommended? ___________
   Was treatment completed? ___________ If not, why? ___________
2. What problems have you had with your teeth? ___________
3. Are you pleased with the appearance of your teeth? ___________
4. Would you like your teeth to be whiter? ___________
5. Is there any specific treatment you would like to discuss? ___________
6. What do you feel the condition of your mouth is now? ___________

General Health Questionnaire

1. Are you being treated by a physician at this time? ☐ Yes ☐ No For what? ___________
2. Have you ever had any complications following dental treatment? ☐ Yes ☐ No ___________
   If yes, please explain ___________
3. Have you ever taken cortico steroids? ___________ When? ___________ For how long? ________ For what? ___________
4. Have you ever taken anti-coagulants (blood thinners)? ___________ If so, when and for how long? ___________
5. Are you allergic to, or have you ever been allergic to aspirin, codeine, novacaine, demerol, penicillin, barbituates, sulfa drugs, iodine, or any other drugs? ___________
6. Have you ever noticed any lumps or swelling in your mouth, head, or neck area? ___________
7. Do you have or have you ever had any of the following?
   Please check those that apply:

☐ AIDS or HIV
☐ Anemia
☐ Are You Pregnant
Date Due ___________
☐ Artificial Heart Valves
☐ Arthritis
☐ Asthma
☐ Bleeding Problems
☐ Chemotherapy

☐ Circulatory Problems
☐ Diabetes
☐ Epilepsy
☐ Glaucoma
☐ GI Ulcers
☐ Heart Disease
☐ Heart Murmur/Mitral Valve Prolapse/Rheumatic Fever/Prosthetic Joint**

☐ Hepatitis, Type ________
☐ High Blood Pressure
☐ History of Cancer
☐ Jaw Pain
☐ Kidney Trouble
☐ Liver Trouble
☐ Low Blood Pressure
☐ Pacemaker
☐ Psychiatric Care

☐ Bisphosphonates (Fosamax, etc.)
☐ Radiation Treatment
☐ Sinus Trouble
☐ Thyroid Problems
☐ Tobacco Use.
How long? _____
☐ Tuberculosis
☐ Venereal Disease

*****PLEASE NOTE THAT CHECKING ANY OF THESE MAY INDICATE A POTENTIALLY SERIOUS HEART (VALVULAR) CONDITION REQUIRING A LETTER FROM A CARDIOLOGIST OR PRIMARY CARE PHYSICIAN BEFORE UNDERTAKING DENTAL WORK OF ANY KIND.***

8. List any current medications you are taking ___________
   ____
9. Do you have any health problems that need further clarification ☐ Yes ☐ No If yes, please explain ___________

Please continue on next page