1076 S. SABLE BLVD.
AURORA, CO 80012
(303) 369-5517

To aid us in providing diagnosis and treatment for your dental needs. Please fill out completely this confidential questionnaire.

HEALTH HISTORY

PATIENT

Name: _____ Date: _____
Address: _____ Birth Date: _____
City: _____ State: _____ Zip: _____ Social Security No.: _____
Age: _____ Sex: _____ Marital Status: _____ Occupation: _____
Home Phone: _____ Business Phone: _____
Please . Whom may we thank for referring you to our office: _____

PERSON RESPONSIBLE FOR PAYMENT

Name: _____ Birth Date: _____
Relationship to patient: _____ Social Security No.: _____
Dental Insurance Carrier 1. _____ 2. _____
Address: _____ City _____ State: _____ Zip: _____
Employer: _____ Phone: _____

HEALTH HISTORY *(Please check the correct box)*

Name of family physician _____ Address: _____
How is your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Do you have, or have you ever had any of the following? *(Please check the correct box)*

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Heart Disease	☐	☐	Diabetes	☐	☐	Tumor History	☐	☐	Liver or Kidney Disease
☐	☐	High Blood Pressure	☐	☐	Stroke	☐	☐	Venereal Disease	☐	☐	Tuberculosis
☐	☐	Blood Disorder, Anemia	☐	☐	Epilepsy	☐	☐	Sinus Trouble	☐	☐	Asthma, Emphysema
☐	☐	Rheumatic Fever	☐	☐	Fainting	☐	☐	Ulcers	☐	☐	Allergies
☐	☐	Heart Murmur	☐	☐	Psychiatric Treatment	☐	☐	Hepatitis	☐	☐	AIDS
☐	☐	Thyroid Disease	☐	☐	Arthritis	☐	☐	Radiation Treatment			

Have you ever been hospitalized and /or had surgery within the last five years? (If YES, Please explain)

_____	YES	NO
_____	YES	NO
Are you under the care of a physician now? Explain _____	YES	NO
Are you taking medication, drugs or pills, over the counter? (If yes, list) _____	YES	NO
Are you allergic or sensitive to penicillin or any other drugs or medicine? Explain _____	YES	NO
Do you have any disease, condition or problem not listed above? (if yes, list) _____	YES	NO
Do you smoke? _____	YES	NO
WOMEN: Are you pregnant? YES ____ NO ____ Delivery Date _____	YES	NO
Remarks: _____	YES	NO
_____	YES	NO

DENTAL HISTORY *(please circle)*

Are you now in discomfort, requiring our immediate attention? _____	YES	NO
Have you had regular dental checkups? _____	YES	NO
When was your last dental visit? _____ What was done then? _____	YES	NO
Do you like the appearance of your teeth? _____	YES	NO
Do your gums bleed when brushing or flossing? _____	YES	NO
Have you been told you have a gum problem? _____	YES	NO
Have you lost many teeth? Why? _____	YES	NO
Do you feel you will eventually lose all your teeth? _____	YES	NO
Are you apprehensive about receiving any dental treatment? _____	YES	NO
Have there been any complications during previous dental treatment? _____	YES	NO

TREATMENT AUTHORIZATION AND ACKNOWLEDGEMENT

I consent to treatment as necessary or desirable to the care of patient first named above, for the diagnosis of dental disease, deformity or treatment of dental emergency. These procedures may include radiographs, models and intraoral examination. In the case of a dental emergency, I consent to treatment as deemed necessary by the doctor, understanding that the procedures will be explained in advance. I give my consent to the use of local anesthetic and relaxants for completing the necessary dental treatment.

I HAVE READ AND UNDERSTAND AND AGREE TO THE ABOVE POLICY

Patient Signature _____ Date _____ Dr. Signature _____ Date _____