EARNEY DENTAL ASSOCIATES, INC.

HEALTH HISTORY

NAME Last First M.I. BIRTHDATE AGE

NAME OF SPOUSE HOME PHONE (AREA CODE + NUMBER) YOUR SOCIAL SECURITY NO.

RESIDENCE ADDRESS CITY STATE ZIP

EMPLOYED BY CITY STATE BUSINESS PHONE

REFERRED BY ADDRESS

WHO WILL PAY FOR THIS ACCOUNT?

NAME OF YOUR DENTAL INSURANCE COMPANY

It is important that we know about your dental and medical history. Many things have a direct bearing on your dental health. We will review the questionnaire and discuss it with you in detail. Information you give us is strictly confidential and will not be released to anyone without your permission.

YOUR DENTAL HISTORY

Are you having any discomfort at this time_____

How long since you have been to a dentist _____

What was done then_____

Did you have X-Rays_____ **How** often did you visit a dentist before then_____ **When** were your teeth extracted_____ Why_____

_____

Any complications with extractions_____

Have they ever been replaced by: _____

(1) Removable Partial_____ (2) Denture_____

How long have you worn dentures _____

How old are your present dentures_____

Do your dentures hurt _____

Do your dentures stay in place_____

Do you use denture adhesive_____

Have you ever been told you need implants_____

Do you like the way your denture teeth look_____

Do you have any natural teeth remaining_____

Are your teeth sensitive to heat _____ to cold_____ to sweets_____ to sour_____ **How** often do you brush your teeth_____ When_____

_____

Do you feel you have bad breath at times_____

Unpleasant taste in mouth_____

Any pain in or around your ears_____

Do you hear popping, clicking or snapping noises when you chew_____ **Do** you have any nasal obstruction_____ **Are** you aware of any swelling or lump in your mouth_____

MEDICAL HISTORY

PHYSICIAN'S NAME _____ Date of last physical exam _____

Do you have or have you had any of the following. Please indicate with check mark (✓).

___ Any heart problems
___ High blood pressure
___ Low blood pressure
___ Circulatory problems
___ Nervous problems
___ Radiation treatments
___ Excessive bleeding
___ Allergies to anesthetics
___ Allergies to medicines or drugs
___ Allergies to _____
___ Anemia
___ Arthritis
___ Asthma
___ Diabetes
___ Hepatitis
___ HIV
___ Malignancies
___ Measles
___ Mumps
___ Psychiatric care
___ Rheumatic Fever
___ Scarlet Fever
___ Sinus Problems
___ Stroke
___ Typhoid Fever
___ Tonsillitis
___ Tuberculosis
___ Ulcer
___ Venereal Disease

Are you pregnant _____ Blood Pressure: S_____/D_____/_____

Please describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your dental treatment. Please list all medications you are presently taking, including birth control pills. This is important as some medications we may want to use may interact with medications you are taking.

_____

_____

_____

_____

_____

I certify that I have read and understand the above information. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Date _____ Your Signature _____

A finance charge of 18% APR will be added to outstanding accounts past 60 days.

Our office is fully committed to compliance with HIPAA guidelines by appropriately maintaining our patient information and billing processes in a secure and private manner in compliance with national standards.