WELCOME TO OUR OFFICE

FRED KNIGHT, D.D.S.
3084 West Ramsey Street
Banning, CA 92220
(951) 849-9640

TODAY'S DATE _____

Thank you for choosing our office.
In order to serve you properly we will need the following information. (Please print.) All information will be kept strictly confidential.

Patient's name	Preferred name	Birth date	Marital status ☐ Separated ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Residence address	City	State	Zip	Home phone

If child, parent's name or guardian's name	Cell phone

Name of employer	Address	Business phone

Social security number	Driver's license	Occupation

Name of spouse	Birth date	Social Security number

Do you have dental insurance? ☐ Yes ☐ No	Ins. co. name & address

Subscriber name	Policy no.	Certificate no.	Is it through your employer? ☐ Yes ☐ No

Is there secondary insurance, ☐ Yes spouse second carrier, etc.? ☐ No	Name & address of spouse employer	Business phone

Secondary insurance name & address	Policy no.	Certificate no.

Person financially responsible for this account	Address	Relationship to patient

Nearest friend or relative not residing with you	Relationship to patient	Phone

Whom may we thank for referring you?

What is your chief dental complaint?

I authorize this office to release any information necessary to expedite insurance claims. I understand that I am responsible for all charges, regardless of insurance coverage.

Patient, Parent, or Guardian Signature_____ Date_____

Please answer each question.

MEDICAL HISTORY

1. Are you in good health? ..... Yes ____ No ____
2. Date of last physical examination _____
3. Are you now under the care of a physician? ..... Yes ____ No ____
   If so, what is the condition being treated? _____
4. Have you ever had any serious illness or operation? ..... Yes ____ No ____
   If so, what illness or operation? _____
5. Have you ever been hospitalized? ..... Yes ____ No ____
   If so, what was the problem? _____
6. Are you taking any medication? ..... Yes _____ No _____ or any recreational drugs (marijuana, cocaine, etc.)? ..... Yes ____ No ____
   If so, what? _____ What dosage? _____
7. Are you sensitive or allergic to any drugs?..... Penicillin ☐ Y ☐ N Tetracycline ☐ Y ☐ N Aspirin ☐ Y ☐ N Codeine ☐ Y ☐ N
   Other ☐ Y ☐ N If Other, what drugs? _____
8. Do you have or have you had any of the following: (Please check ✓ known conditions - Y box for YES, N box for NO)

Y N	Y N	Y N	Y N	Y N	Y N
☐ ☐ Anemia	☐ ☐ Cold Sores	☐ ☐ Sinus Trouble	☐ ☐ Blood Transfusion	☐ ☐ Pain in Jaw Joints	☐ ☐ X-Ray or Cobalt Treatment
☐ ☐ Herpes	☐ ☐ Hemophilia	☐ ☐ Blood Disease	☐ ☐ Joint Replacement	☐ ☐ Respiratory Disease	☐ ☐ Fainting Spells or Seizures
☐ ☐ Stroke	☐ ☐ Rheumatism	☐ ☐ Drug Addiction	☐ ☐ Nervous Disorders	☐ ☐ Sickle Cell Disease	☐ ☐ Chemotherapy (Cancer, Leukemia)
☐ ☐ Ulcers	☐ ☐ Bruise Easily	☐ ☐ Kidney Disease	☐ ☐ Tumors or Growths	☐ ☐ Tuberculosis (T.B.)	☐ ☐ Radiation Treatment of any kind
☐ ☐ Diabetes	☐ ☐ Head Injuries	☐ ☐ Stomach Ulcers	☐ ☐ Allergies or Hives	☐ ☐ Epilepsy or Seizures	☐ ☐ Hepatitis or Jaundice
☐ ☐ Glaucoma	☐ ☐ Heart Failure	☐ ☐ Angina Pectoris	☐ ☐ Cortisone Medicine	☐ ☐ Psychiatric Treatment	☐ ☐ Venereal Disease (Syphilis, Gonorrhea)
☐ ☐ Arthritis	☐ ☐ Liver Disease	☐ ☐ Mental Disorder	☐ ☐ Excessive Bleeding	☐ ☐ Congenital Heart Lesions	☐ ☐ Acquired Immune Deficiency Syndrome (AIDS)
☐ ☐ Emphysema	☐ ☐ Scarlet Fever	☐ ☐ Thyroid Disease	☐ ☐ Asthma	☐ ☐ Difficulty in Swallowing	☐ ☐ TMJ (Temporomandibular joint)
☐ ☐ Hay Fever	☐ ☐ Chicken Pox	☐ ☐ Cerebral Palsy	☐ ☐ High Blood Pressure	☐ ☐ Heart Ailments or Attack	☐ ☐ Other
☐ ☐ Tonsillitis	☐ ☐ AIDS Related Complex		☐ ☐ Latex Allergy	☐ ☐ Phen-Fen Medication	
☐ Y ☐ N Mitral Valve Prolapse		☐ Y ☐ N Heart Murmur		☐ Y ☐ N Rheumatic Fever	☐ Y ☐ N Artificial Prosthesis

   If yes, has your physician ever told you that you must take preventative antibiotics for your dental treatment? ..... Yes ____ No ____
9. Do you wear a cardiac pacemaker, or have you had heart surgery? ..... Yes ____ No ____
10. Do you have any disease, condition or problem not listed that you think we should know about? ..... Yes ____ No ____
    If so, what? _____
11. Do you smoke? If yes, how much? _____ per day ..... Yes ____ No ____
12. (Women) Are you pregnant? If so, how many months _____ ..... Yes ____ No ____
13. (Women) Do you have any problems associated with your menstrual period? ..... Yes ____ No ____
14. (Women) Do you take birth control pills? ..... Yes ____ No ____

DENTAL HISTORY

Have you ever had any unfavorable reaction from a-local anesthetic? ..... Yes ____ No ____
Have you had any serious trouble associated with any previous dental treatment? ..... Yes ____ No ____
If so, explain _____

Do your gums bleed when you brush? ..... Yes ____ No ____ Are your teeth sensitive to heat or cold? ..... Yes ____ No ____
Are your teeth sensitive to pressure? ..... Yes ____ No ____ Are your teeth sensitive to sweets? ..... Yes ____ No ____
Do you grind or clench your teeth? ..... Yes ____ No ____ Do you have any fear of dental work? ..... Yes ____ No ____
Date of last examination or treatment _____
How do you feel about the appearance of your teeth? _____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or if my medications change, I will, without fail, inform the doctor at my next appointment.

Date _____ **Signature** _____

Year 2
Changes in Health _____

Date _____ **Signature** _____

Year 3
Changes in Health _____

Date _____ **Signature** _____

Health Questionnaire MUST be updated every year!

REVIEWED BY

_____ YEAR 1

_____ YEAR 2

_____ YEAR 3

DO NOT WRITE IN THIS SPACE

	YEAR 1	YEAR 2	YEAR 3
Date			
BP	/	/	/
Pulse			
Temp			
By			

CONSENT FOR TREATMENT:

I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

All services are rendered and accepted under the terms and conditions printed on the reverse hereof

Signed: _____ **Date:** _____

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

Relationship to the patient: _____