Brien V. Harvey, DDS, MS
Periodontics & Dental Implants

## PATIENT INFORMATION

❑ Mr.
❑ Mrs.
❑ Miss
❑ Ms. ______________________________________________

Last Name | First | M | Preferred Name | Birthdate | Age

______________________________________________

Home Address | City | State | Zip | Home Phone #

______________________________________________

Person Responsible for Account | Cell Phone | Email | Billing Address

**Your:**

Occupation__________________ Employer_____________________

Business Address____________________________________________

City/Zip___________________________Bus. Phone______________

**Your Spouse: (Name)** ______________________________________

Occupation__________________ Employer_____________________

Business Address____________________________________________

City/Zip___________________________ Bus. Phone______________

## INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE

Employer:_______________________________________________

Insurance Company:_______________________________________

Employee:_______________________________________________

Cardholders D.O.B._______________________________________

Group No._______________________________________________

Participant No.__________________________________________

I authorize payment of insurance benefits directly
to the dentist of record

_______________________________________________ (Signature)

SECONDARY DENTAL INSURANCE

Employer:_______________________________________________

Insurance Company:_______________________________________

Employee:_______________________________________________

Cardholders D.O.B._______________________________________

Group No._______________________________________________

Participant No.__________________________________________

I authorize release of any necessary medical information
to Insurance Company

_______________________________________________ (Signature)

## GETTING TO KNOW YOU

Hometown_______________________________________________ Referred to us by__________________________________________

Person to contact in case of emergency_______________________________________________ Phone:______________________________

Closest relative not living with you___________________________________________________ Phone:______________________________

Is another member of your family, or a relative a patient at our office? ❑ Yes ❑ No

## CONSENT

The undersigned hereby authorizes Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient)_____________________________________________and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless prior arrangements have been made.

Patient__________________________________________________ Date____________________ Witness_____________________________________________

Parent or Responsible Party_________________________________________________________Relationship to Patient________________________________

# HEALTH QUESTIONNAIRE

Name of Primary Care Physician ____________________________
Phone Number ____________________________

Specialist ____________________________
Type: ____________________________

Height ________________
Weight ________________
BMI ________________

★ Please circle the appropriate answer.

**1. Are you in good health?** ............ YES NO
2. Has there been any change in your health within the past year? ............ YES NO
3. Date of last physical exam
**4. Are you now under medical care?** ............ YES NO
If so what? ____________________________
____________________________
**5. Have you ever had a serious illness or operation?** ............ YES NO
If so, explain ____________________________
____________________________
____________________________
**6. Do you have or have you ever had any of the following?**
- a. Rheumatic fever or rheumatic heart disease ............ YES NO
- b. Congenital heart disease ............ YES NO
- c. Cardiovascular disease (heart trouble, high blood pressure) . YES NO
  Explain ____________________________
- d. Allergy or hay fever ............ YES NO
- e. Asthma ............ YES NO
- f. Hives or skin rash ............ YES NO
- g. Fainting spells ............ YES NO
- h. Diabetes ............ YES NO
- i. Hepatitis, jaundice, or liver disease ............ YES NO
- j. Inflammatory rheumatism (painful swollen joints) ............ YES NO
- k. Arthritis ............ YES NO
- l. Stomach ulcers ............ YES NO
- m. Kidney trouble ............ YES NO
- n. Tuberculosis ............ YES NO
- o. Persistent cough or cough up blood ............ YES NO
- p. Epilepsy or seizure disorder ............ YES NO
- q. Artificial joint (knee, hip, other prosthesis) ............ YES NO
  what joint? ________________ when? ________________
- r. Substance abuse (alcoholism, drug abuse) ............ YES NO

7. Do you have pain in your chest upon exertion? ............ YES NO
8. Are you ever short of breath after mild exercise? ............ YES NO
9. Do your ankles swell? ............ YES NO
10. Do you ever get short of breath when you lie down, or do you require extra pillows to sleep? ............ YES NO
11. Have you had abnormal bleeding associated with previous surgery, extractions or accidents? ............ YES NO
12. Have you ever required a blood transfusion ............ YES NO
13. Do you ever have any blood disorders such as anemia, etc.? ............ YES NO
14. Have you ever been exposed to anyone who has A.I.D.S? ............ YES NO
15. Are you HIV positive? ............ YES NO
16. Have you ever had surgery or x-ray treatment for a tumor, growth, or other condition? ............ YES NO
**17. Are you taking any of the following?**
- a. Antibiotics or sulfa drugs ............ YES NO
- b. Anticoagulants (blood thinners) ............ YES NO
- c. Medicine for high blood pressure ............ YES NO
- d. Cortisone, prednisone, or steroids of any kind ............ YES NO
- e. Tranquilizers, anti-anxiety or sedative ............ YES NO
- f. Aspirin or anti inflammatory agent ............ YES NO
- g. Dilantin or other convulsant ............ YES NO
- h. Insulin or other hypoglycemics ............ YES NO
- i. Digitalis or drugs for heart trouble ............ YES NO
- j. Nitroglycerin ............ YES NO
- k. Narcotic Analgesics (pain pills) ............ YES NO
- l. Birth Control "pill" ............ YES NO
- m. Alcohol, Antabuse ............ YES NO
- n. Osteoporosis Pills such as Fosamax or Actonel ............ YES NO
- **o. List medications currently taking:** ____________________________
  ____________________________
- p. Do you smoke? ............ YES NO
- q. How long? ____________________________

**18. Are you allergic to or have you ever reacted adversely to any of the following?**
- a. Local anesthetics (Novocaine, Lidocaine, etc.) ............ YES NO
- b. Penicillin or other antibiotics ............ YES NO
- c. Aspirin or anti-inflammatory drugs ............ YES NO
- d. Barbiturates, sedatives or sleeping pills ............ YES NO
- e. Narcotic analgesics (pain pills) ............ YES NO
- f. Any other? ____________________________
  ____________________________
  ____________________________

19. Have you had any trouble associated with any previous dental treatment? ............ YES NO
If so, please explain ____________________________
____________________________
____________________________
20. Do you have any disease, condition, or problem not listed?
If so, please explain ____________________________
____________________________
____________________________
21. Reason for seeking dental treatment at this office
____________________________
22. Date of last dental exam ____________________________
23. Have you ever been treated for any gum disease (gingivitis, periodontitis, trenchmouth, pyorhea)? ............ YES NO
How long ago? ____________________________
24. Do your gums bleed when you brush your teeth? ............ YES NO
25. Do you grind or clench your teeth? ............ YES NO
26. Have you often had toothaches? ............ YES NO
27. Have you had frequent sores in your mouth? ............ YES NO
28. Do you mouth-breath while awake or asleep? ............ YES NO
29. Have you had any injuries to your mouth or jaws? ............ YES NO
If so, please explain ____________________________
____________________________
30. Have you experienced:
- a. Clicking of the jaw? ............ YES NO
- b. Pain (joint, ear, side of face)? ............ YES NO
- c. Difficulty in opening or closing? ............ YES NO

31. Do you have any sores or swelling of your mouth or jaws? ............ YES NO
32. Are you interested in keeping your teeth? ............ YES NO
33. Are you dissatisfied with the appearance of your teeth? ............ YES NO
34. Have you been satisfied with your previous dental care? ............ YES NO
If not please explain ____________________________
____________________________

Women
35. Are you pregnant? ............ YES NO

The undersigned agrees that the information above is accurate.

____________________________ Signature
________________ Date

Please feel free to ask the Doctor any questions regarding your general health or dentistry.