

Robert J. Farbman, D.D.S., P.A.

PATIENT QUESTIONNAIRE

Please fill in your answers as thoroughly as possible. All information, of course, will be held in strict confidence.

Patient Information

- Mr. Mrs.
 Dr. Miss
 Ms.

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Address: _____
Street Apartment #
City State Zip Code

Phone (Home): _____ (Work): _____ Ext: _____

Marital Status: Single Married Divorced Widowed

Birth Date: _____ Social Security No: _____

E-Mail Address: _____

Name of Person Responsible for Payment: _____

Employment Information

Employer Name: _____ Occupation: _____

Address: _____
Street
City State Zip Code

Spouse Information

Spouse Name: _____
Last, First MI (Preferred Name)

Employer Name: _____ Occupation: _____

Address: _____
Street
City State Zip Code Phone Number

Referral Information

Has a family member ever been treated in our office? Yes No

Name: _____

Whom may we thank for referring you to our office? _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I certify that I have read and understand the above conditions of treatment and payment and agree to their content.

Signature of patient, parent, or guardian _____ Date: _____ Relationship to Patient: _____

OFFICE USE ONLY: Name: _____

Chart No. _____

Year: _____

Please complete your health history on the reverse side.

Medical Information

General Health (please check): Good Fair Poor

Physician's Name: _____

Address: _____
Street City, State Zip Code Phone

When did you have your last complete physical examination? _____

Have you had recent surgery? Yes No

Are you being treated for anything now? Yes No

Health Information

Have you ever had any of the following? Please check those that apply:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> AIDS or HIV + | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Excessive Bleeding |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> GI / Stomach Problems | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Hip or Knee Replacement | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Angina | <input type="checkbox"/> Anemia | <input type="checkbox"/> Pace Maker |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Other _____ |

• Are you allergic to: Penicillin Codeine Novocaine Aspirin Adrenaline
Other allergies: _____

• Do you take Coumadin? Yes No

• Have you ever taken Phen-Fen or Redux diet pills? Yes No

• Do you take aspirin? Yes No
If yes, tablets per day? _____

• Have you ever been treated with radiation? Yes No

• If female: Are you pregnant? Yes No If yes, how long? _____
Are you taking birth control pills? Yes No

• Type of dental patient: Good Fair Apprehensive

• Have you previously had periodontal treatment? Yes No
If yes, what year? _____

• Do you smoke? Yes No
Do you chew tobacco? Yes No

• Alcohol Consumption: None Social Mild Moderate

• Are you "high-strung" or easily stressed? Yes No

• What is your current blood pressure reading? _____

• Please indicate any other health information on the lines below.

List all medications you are presently taking:

Please list all medications you are presently taking, in the box on the right.

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. If I ever have any change in my health, I will inform Dr. Farbman at the next appointment without fail.

Signature of patient, parent, or guardian