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
Patient Name: ☐ Ms. _____ Date: _____
Last **First** **MI** **(Preferred Name)**

Address: _____
Street **Apartment #**

_____
City **State** **Zip Code**

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

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Birth Date: _____

E-Mail Address: _____ Social Security No. _____

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? _____

HIPAA Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

I have received a copy of this office's Notice of Privacy Practices.

_____ _____ _____
Signature of patient, parent, or guardian **Print Name** **Date**

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. I understand that payment for treatment is due in full at the time services are performed unless other financial arrangements have been made in advance.

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 **Print Name** **Date**

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

Name of Person to Contact in Case of Emergency:_____ Phone:_____

Health Information

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

☐ Liver Disease	☐ AIDS or HIV +	☐ Ulcer	☐ Excessive Bleeding
☐ Hepatitis	☐ Tuberculosis	☐ GI / Stomach Problems	☐ Jaundice
☐ Rheumatic Fever	☐ Diabetes	☐ Asthma	☐ Osteoporosis
☐ Mitral Valve Prolapse	☐ Hip or Knee Replacement	☐ Emphysema	☐ Stroke
☐ Heart Murmur	☐ Angina	☐ Anemia	☐ Pace Maker
☐ Artificial Heart Valve	☐ High Blood Pressure	☐ Epilepsy	☐ Cancer
☐ Heart Trouble	☐ Irregular Heart Beat	☐ Blood Transfusion	☐ Other _____

- Are you allergic to: ☐ Penicillin ☐ Codeine ☐ Novocaine ☐ Aspirin ☐ Adrenaline
  Other allergies: _____
- Have you ever taken bone-strengthening medications (oral or intravenous)? ☐ Yes ☐ No
- Do you take Coumadin? ☐ 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 If yes, packs per day? _____
  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