Health Questionnaire (page 1 of 2)

Jennifer Herbert, D.D.S.
109 South Seventh Street #133 • Minneapolis, Minnesota • 55402 • 612-332-0592

Patient's Name _____ Date of Birth_____

Please check the appropriate box for any condition that you have had in the past or have now.

1. CARDIOVASCULAR

- Heart failure ☐
- Heart disease or heart attack ☐
- Angina pectoris or chest pain ☐
- High blood pressure ☐
- Heart murmur ☐
- Mitral valve prolapse ☐
- Rheumatic fever or disease ☐
- Congenital heart defect ☐
- Artificial heart valve ☐
- Arrhythmias ☐
- Heart pacemaker or defibrillator ☐
- Heart surgery or transplant ☐
- Stroke ☐
- Aneurysm ☐
- Bacterial endocarditis ☐
- Other heart problems ☐

2. HEMATOLOGIC

- Blood transfusion ☐
- Anemia ☐
- Hemophilia ☐
- Leukemia ☐
- Sickle cell (anemia) disease ☐
- Tendency to bleed longer than normal ☐
- Platelet disorder ☐

3. NEURAL AND SENSORY

- Eye pain ☐
- Vision problems ☐
- Wear contact lenses ☐
- Glaucoma ☐
- Earaches, ringing in ears ☐
- Hearing loss ☐
- Severe headaches ☐
- Fainting or dizzy spells ☐
- Epilepsy, seizures, or convulsions ☐
- Anxiety ☐
- Depression ☐

4. GASTROINTESTINAL

- Stomach/intestinal ulcers ☐
- Gastritis ☐
- Colitis ☐
- Persistent diarrhea ☐
- Hepatitis ☐

If yes, what type: **A** **B** **C**
Diagnosed when? _____

- Liver disease ☐
- Jaundice ☐
- Cirrhosis ☐

5. RESPIRATORY

- Hay fever ☐
- Sinus trouble ☐
- Asthma ☐
- Chronic cough ☐
- Cough up blood ☐
- Emphysema ☐
- Chronic obstructive pulmonary disease (COPD) ☐
- Tuberculosis (TB) ☐
- Breathing difficulties ☐

6. DERMAL/MUCOTANEOUS/ MUSCULOSKELETAL

- Allergy to latex (rubber) ☐
- Skin rash ☐
- Dark mole(s) (recent changes in appearance) ☐
- Night sweats ☐
- Sore muscles ☐
- Stiff joints ☐
- Arthritis ☐
- Artificial joint ☐
- Fever blister; cold sore ☐
- Mouth ulcers or canker sores ☐
- Colored or discolored areas in mouth ☐

7. ENDOCRINE

- Diabetes ☐
- Thyroid disease ☐

8. URINARY

- Urinate frequently ☐
- Kidney or bladder problem ☐

9. OTHER CONDITIONS

- Frequent sore throat ☐
- Enlarged lymph nodes or gland ☐
- Tobacco use ☐
- Drug or alcohol addiction (recovering or current) ☐
- Anorexia or bulimia ☐
- Tumor or cancer ☐
- Radiation treatment ☐
- Chemotherapy ☐
- HIV positive ☐
- Aids ☐

Have you been tested for HIV & AIDS? YES NO

Health Questionnaire (page 2 of 2)

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Patient's Name _____ Date of Birth_____

	YES	NO
10. Do you have a disease, problem or condition not listed? If yes, please list _____ _____	☐	☐
11. Are you currently under the care of a physician? For what? _____ Physician's name _____ Clinic _____ Phone # _____	☐	☐
12. Are you taking (or are supposed to be taking) any medicine, drug, or pills of any kind? If yes, what kind, dose? _____	☐	☐
13. Do you have reactions or allergies to drugs or medicine?	☐	☐
14. Have you had a reaction to dental or general anesthetic?	☐	☐
15. Have you ever had any operations or surgeries? Describe the problem and any complications: _____	☐	☐
16. Have you ever been hospitalized? _____	☐	☐
17. Have you unintentionally lost or gained more than 10 pounds in the past year?	☐	☐
18. Have you ever taken the weight loss drugs Phen-fen or Redux?	☐	☐
19. Are you on a special diet?	☐	☐
20. Have you taken Cortisone or other steroids in the past 12 months?	☐	☐
21. Have you ever been told you need to be pre-medicated with antibiotics for dental appointments?	☐	☐
22. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired.	☐	☐
23. WOMEN: Are you pregnant?	☐	☐
Are you nursing?	☐	☐

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 inform the dentist at the next appointment without fail.

_____ _____
Date Patient, parent, or guardian signature

REVIEW AND UPDATE

Date	Dr .& Hyg	Patient, parent, or guardian signature	Changes in health status
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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Patient Information

Patient's Name _____Date of Birth _____

Home Address _____ City, State & Zip _____

Email _____

Home Phone_____ Work Phone _____ Cell Phone _____

Who may we thank for referring you to us? (name & relationship)_____

Person to contact in case of an emergency? _____Phone Number _____

Person responsible for Payment (name and address) _____

_____

Insurance Information

Do you have dental insurance? YES NO Name of Insurance Co. _____Policy or Group #_____

Policy Holder's Name _____ Policy Holder's Birth Date _____

Policy Holder's Address if different from patient's_____

_____

Dental Insurance ID # or Social Security #_____

Policy Holder's Employer _____

Patient's relationship to policy holder (if someone other than patient) _____

Patient's college status Part-time student Full-time student

Patient's college and city _____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my patient or insurance information, I will inform J&D Dental at my next appointment.

_____ _____

Date Patient, parent, or guardian signature

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Financial Policy

- For patients without dental insurance: payment is due on the day of service, unless payment arrangements had been made prior to starting treatment.

- Methods of payment include: cash, check, VISA, MasterCard, American Express, Discover or CareCredit.

- Insurance assignment and management:
    - Patients must provide accurate insurance billing information at the time of the appointment.
    - The coverage received will depend on the quality of the insurance plan that you or your employer purchased, not the treatment recommended by the dentist.
    - We cannot guarantee the amounts of coverage offered by your insurance company as each policy is different.
    - Although we attempt to prior authorize all treatment it is your responsibility to know what is or is not covered by your insurance plan as well as any requirements or limitations.

- Patient authorizes J&D Dental to release any information concerning his/her case to his/her insurance company or to any dental specialist to whom the patient may be referred.

- A annual finance charge of 6% will be applied to all accounts over 60 days past due.

- All returned checks will be assessed a $20.00 fee.

- In the event the patient's account is not paid and is sent to our collection agency, the patient will be dismissed from the office and will be responsible for all fees incurred for the collection of the bill (i.e. attorney fees, court costs and collection agency fees) Our collection agency reports to the Credit Bureaus.

- Your appointment time has been reserved exclusively for you. Any last minute changes affects many patients. **24 hours notice is needed to avoid a $40.00 charge.**

I have read and understand the above information. I understand that I am responsible (regardless of my insurance coverage) for any charges incurred from the services rendered.

NAME (*please print*)_____

SIGNATURE_____ DATE_____