HEALTH HISTORY

Since any medical or health problems that you may have or medications that you may be taking may influence your treatment , we are obligated both professionally and legally to ask the following questions.

1. Are you under the care of a physician for any reason? ..... yes no

2. Has your blood pressure been checked within the last year? ..... yes no

3. When did you last have a complete physical exam? _____

4. Do you have, or have you had, any of the following conditions?

Any type of heart disease	yes	no	High blood pressure	yes	no
Heart murmur	yes	no	Anemia or other blood disorder	yes	no
Heart attack	yes	no	Prolonged bleeding	yes	no
Any major surgery	yes	no	Thyroid or parathyroid disorder	yes	no
Kidney disease	yes	no	Venereal diseases	yes	no
Hepatitis, jaundice, liver disease	yes	no	A tumor or abnormal growth	yes	no
Immunosuppresive disease	yes	no	Radiation treatment	yes	no
Epilepsy, fainting or seizures	yes	no	Glaucoma	yes	no
Tuberculosis	yes	no	Artificial joint (prosthesis)	yes	no
Diabetes	yes	no	Artificial heart valve	yes	no
Stomach or duodenal ulcer	yes	no	Heart pacemaker	yes	no

5. Are you a smoker? ..... yes no

6. Are you taking any prescription or non-prescription drugs? ..... yes no
   Names of drugs:

   Conditions for which they are taken:

7. Have you had any allergic or adverse reactions to any drugs (novocaines, penicillin, sulfas, etc.)? ..... yes no
   Name of drugs:

   The reaction you had:

8. If you are a woman, are you pregnant? ..... yes no

9. Do you have any other conditions that should be mentioned? ..... yes no
   If so, please explain: (use other side if more space is needed)

Your Signature _____ Date _____

Reviewed by: Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Peter D. Agnos, D.D.S., P.S.

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Patient's Name

First Middle Last

If a child, Parents' name

Address City Zip

Telephone Birthdate Social Security No.

Marital Status: Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐

Responsible Party

Person Responsible for payment of Account

Employer

Employer Occupation

Address City Zip

Telephone

Insurance

Dental Insurance Company Policy No.

Spouse

First Middle Last

Employer

Address City Zip

Telephone Birthdate Social Security No.

Insurance

Dental Insurance Company Policy No.

Emergency Contact

First Middle Last Relationship

Address City Telephone

Dentist and Physician

Referred by:

Your Dentist: How long?:

Your Physician How long?

Payment Policy

Payment is expected when services are rendered unless prior arrangements are made with the office manager.

1. I will pay for services when rendered. Yes ☐ No ☐
2. I would like to discuss financial arrangements. Yes ☐ No ☐

Assignment & Release

I hereby authorize my insurance benefits to be paid directly to Dr. Agnos. I am financially responsible for any balances due. I also authorize Dr. Agnos to release any information required for this claim.

Signature Date

Permission is granted to Dr. Agnos to perform any necessary treatment for this child.

Signature Date