PLEASE COMPLETE BOTH SIDES, SIGN AND BRING WITH YOU – THANK YOU

Oscar Morejón, D.M.D.   Michele McCall, D.M.D., M.S.

Date: ____________

CONFIDENTIAL HEALTH QUESTIONNAIRE

Name: ______________________ Date of Birth: ____________

Address: Residence - ______________________ Social Security #: ____________

______________________ Phone: ____________

Business - ______________________ Cell: ____________

______________________ Phone: ____________

Marital Status: Single ______ Married ______ Divorced ______ Widowed ______

Occupation: Self - ______________________ Spouse - ____________

Employer: Self - ______________________ Spouse - ____________

Whom may we thank for referring you to us? ______________________

Your Dentist's Name: ____________ Your Physician's Name: ____________

Date of Last Physical Exam: ____________ Is your general health? (circle one) Good Fair Poor

The following information is for your general welfare whether you are here
for diagnostic consultation, limited, or extensive treatment.
(CIRCLE THE ANSWER WHICH APPLIES: Y - YES N - NO)

Do you think your gums or teeth are affecting your general health?........................ Y N

Are you now under the care of a physician?........................ Y N

Has your general health changed in the last year? .... Y N

Do you smoke or use tobacco in any other form? .... Y N

Are you taking ANY drugs or medicines at the present time?........................ Y N

If so, what? ______________________

Have you taken cortisone or ACTH within the last year? .... Y N

Have you ever had an abnormal reaction to any of the following?

Antibiotics	Y	N	Demerol	Y	N	Penicillin	Y	N
Aspirin	Y	N	Dental Anesthetic	Y	N	Other: ____________		
Codeine	Y	N	Latex	Y	N			

Do you take aspirin, vitamin E, blood thinners or any herbal supplements regularly?........................ Y N

If so, what and dosage? ______________________

Do you bleed for a long time after injury or tooth extraction?........................ Y N

Do you bruise easily?........................ Y N

Have you ever had medical x-ray treatment about your neck or mouth?........................ Y N

Do you heal? (circle one) Rapidly Normally Slowly

Do you have any allergies to foods, drugs or latex?........................ Y N

Do you ever have chest pains or shortness of breath? .... Y N

Do you have any numbness or tingling in any part of your body? .... Y N

(Continued)

Do you urinate more than six times per day? .... Y N

Are you usually thirsty or frequently have dry mouth? .... Y N

Do you wear contact lenses? .... Y N

Do you have or have you had any of the following?

ANEMIA	Y	N	IMMUNE SUPPRESSIVE DISEASE	Y	N
ARTERIOSCLEROSIS	Y	N	JOINT REPLACEMENT OR IMPLANT	Y	N
ARTHRITIS OR RHEUMATISM	Y	N	KIDNEY TROUBLE	Y	N
ASTHMA/HAY FEVER	Y	N	LIVER DISEASE (JAUNDICE)	Y	N
CHEMOTHERAPY OR RADIATION	Y	N	MENTAL HEALTH CARE	Y	N
COLD SORES/FEVER BLISTERS	Y	N	MITRAL VALVE PROLAPSE	Y	N
DIABETES (SUGAR IN BLOOD)	Y	N	PAIN IN JAW JOINTS	Y	N
EPILEPSY OR SEIZURES	Y	N	PROSTATE TROUBLE (MEN)	Y	N
FREQUENT HEADACHES	Y	N	RHEUMATIC FEVER	Y	N
GLAUCOMA	Y	N	SINUS TROUBLE (SINUSITIS)	Y	N
HEART DISEASE OR ATTACK	Y	N	STROKE	Y	N
HEART MURMUR	Y	N	TENDENCY TO FAINT	Y	N
HEPATITIS A, B OR C	Y	N	THYROID PROBLEMS	Y	N
HIGH/LOW BLOOD PRESSURE	Y	N	TUBERCULOSIS	Y	N
HIV+/AIDS	Y	N	ULCERS	Y	N

Do you consider yourself to be a nervous or tense person? .... Y N

Is your fear of dental treatment? (Circle one) NONE MILD MODERATE SEVERE

Please list any disease, condition, or problem not listed above which you think I should know about?

____

____

FOR WOMEN ONLY:

Are you pregnant or think you may be pregnant? .... Y N

Is your menstrual cycle abnormal or irregular? .... Y N

DENTAL INSURANCE INFORMATION:

Company Name: ________ Policy/Group #: ________ Phone: ________

Company Address: ________ City ________ State ____ Zip ____

Subscriber's: Name ________ Date of Birth ________ SS# ________

Have you ever been a patient of Dr. Bryan Bergens, P.A.? ❑ Yes ❑ No

PLEASE SIGN

SIGNATURE ____________________ **DATE** __________