HEALTH QUESTIONNAIRE

Answers to the following questions are for our records and will be considered confidential. Please circle the correct answer and complete the questions which pertain to you.

1. Are you presently under the care of a physician? **Yes No**
   If so, for what condition are you being treated? _____

   _____

   _____

   Name and Address of Physician _____

   _____

   _____

   Phone _____

2. Is your general health good? **Yes No**

3. Have you ever been hospitalized or had a serious illness? **Yes No**

4. Do you have any artificial joints? **Yes No**

5. Have you had abnormal bleeding associated with previous extractions, surgery or trauma? **Yes No**

   a. Do you bruise easily? **Yes No**

   b. Have you ever required a blood transfusion? **Yes No**

   If so, explain the circumstances

   _____

6 Have you ever tested positive for Acquired immune Deficiency Syndrome (AIDS)? **Yes No**

7. Have you ever tested positive for Human Immunodeficiency Virus (HIV)? **Yes No**

8. Are you allergic or have you reacted adversely to:

   a. Local anesthetics (Epinephrine)? **Yes No**

   b. Penicillin? **Yes No**

   c. Other antibiotics? **Yes No**

   d. Barbiturates, sedatives, sleeping pills? **Yes No**

   e. Aspirin? **Yes No**

   f. Codeine or other narcotics? **Yes No**

   g. Nitrous oxide analgesia? **Yes No**

   h. Have you had an unpleasant experience with ether or any gas administered to you? **Yes No**

   I. Other _____ **Yes No**

9. Have you had any trouble with previous dental work? **Yes No**

   Please Explain

10. Do you take any dietary supplements such as vitamins or proteins? **Yes No**

11. Do you consider yourself a nervous or tense person? **Yes No**

12. Have you ever had a malignant or non-malignant tumor removed? **Yes No**

13. Have you ever had a biopsy? **Yes No**

14. Do you wear a pacemaker? **Yes No**

Do you or have you ever had:

Heart trouble?	**Yes No**	Anemia?	**Yes No**	Jaundice?	**Yes No**
Pain in chest?	**Yes No**	Epilepsy or Convulsions?	**Yes No**	Hepatitis?	**Yes No**
Shortness of breath?	**Yes No**	Glaucoma?	**Yes No**	Prolonged bleeding?	**Yes No**
Swollen ankles?	**Yes No**	Thyroid trouble?	**Yes No**	Stomach ulcer?	**Yes No**
Mitral Valve Prolapse?	**Yes No**	Goiter?	**Yes No**	Venereal Disease?	**Yes No**
Rheumatic Fever?	**Yes No**	Low blood pressure?	**Yes No**	Arthritis?	**Yes No**
Heart Murmur?	**Yes No**	Persistent cough?	**Yes No**	Measles?	**Yes No**
Fainting or Dizziness?	**Yes No**	Hayfever or Asthma?	**Yes No**	Tumor?	**Yes No**
Stroke?	**Yes No**	Tuberculosis?	**Yes No**	Eczema or Hives?	**Yes No**
High blood pressure?	**Yes No**	Kidney Trouble?	**Yes No**	Frequent headaches?	**Yes No**
Diabetes?	**Yes No**	Mental Disorder?	**Yes No**	Herpes?	**Yes No**

Are you now taking or have you In the past three months taken:

Aspirin?	**Yes No**	Nitroglycerin?	**Yes No**	Tranquilizers or sedative?	**Yes No**
Drugs for sleep?	**Yes No**	Drugs for high blood pressure?	**Yes No**	Insulin or Orinase?	**Yes No**
Anticoagulants?	**Yes No**			Digitalis or drug for heart trouble?	**Yes No**
Antibiotics?	**Yes No**	Cortisone, steroids, ACTH?	**Yes No**		
Antihistamines?	**Yes No**			Hormones?	**Yes No**

Do you have any condition, problem, or disease, not mentioned above, about which 1 should know?
Please explain _____

_____

_____

List any additional medications you are presently taking: _____

_____

_____

For your safety it is important for us to know the recreational drugs you are using or have ever used.
1. Please list all recreational drugs: _____

_____

2. Do you drink alcohol? Yes No If yes, how much per week: _____

_____

Women

1. Are you pregnant? **Yes No**

2. Are you presently taking birth control pills? **Yes No**

Comments: _____

_____

_____

_____

_____

_____

Yearly Review.

Have there been any changes in your health since this form was filled out? **Yes No** If so, what? _____

_____

_____

_____

_____

Date: _____

Please read and sign Financial and Insurance Policies on back.

JERRY
ROBERTSON
D.D.S.

9224 SOUTH TOLEDO COURT
TULSA, OKLAHOMA 74137
(918) 492-7263

FINANCIAL AND INSURANCE POLICIES

This disclosure information is submitted in compliance with the Oklahoma Uniform Consumer Credit Code.

Payment is due at the time services are rendered. For your convenience, we do accept MasterCard, Visa or Discover. If you have dental insurance, you should obtain an insurance form from your employer, complete and sign the form, and bring it to our office at the time of your appointment. We will file the completed form with your insurance company. The patient has full responsibility for payment of the services rendered. Your dental insurance is a benefit provided by your employer to help with the costs of medical and dental services. Benefits are based on schedules set up by your employer with the insurance company and have no correlation with dentists' or physicians' actual fees. Should any question arise concerning the amount to be paid by the insurance carrier for a particular service, it should be handled directly between the patient and the carrier. We will assist you as much as possible and provide any necessary information to help you obtain maximum benefits and reimbursement.

In consideration of your rendering professional services to me, I agree to the above regarding the billing and payment of such services.

Signature _____ Date _____

JERRY ROBERTSON D.D.S.

9224 SOUTH TOLEDO COURT
TULSA, OKLAHOMA 74137
(918) 492-7263

REGISTRATION

Date _____

Patient's Name _____

Single _____ Married _____ Divorced _____ Widowed _____ Minor _____ Date of Birth _____

Name of Spouse _____

If a Child, Parent's Name _____

Residence Address _____

City _____ State _____ Zip Code _____

Telephone: Residence _____ Business _____

Cell Phone: _____

Employed By: _____

Present Position: _____

Business Address: _____

Spouse Employed By: _____

Present Position: _____

Whom may we thank for referring you? _____

Person Responsible for Payment of Account: _____
(and address if different from above)

In Case of Emergency please notify _____
Phone

Purpose of Call _____

Name of Dental Insurance Company _____

Group # _____ Social Security No. of Insured: _____

Address: _____