This information is strictly confidential and will not be released to anyone.
Thank you for taking the time to completely fill out this questionaire.

HEALTH HISTORY and REGISTRATION

Name_____ (Nick name)_____ Birthdate_____
Home address_____City_____Zip_____
Occupation_____ Home phone_____ Email_____
Your employer_____ Work phone_____ Cell/Pager_____
Spouse name_____ Spouse employer_____ Work phone_____
IF PATIENT IS A MINOR-
Names: Mother_____ Father_____
Work phone mother_____ Father_____

Who may we thank for referring you to our office?_____

Height_____ Weight_____ General health status_____ Male ___ Female___
Physician name_____ Phone _____ Date last physical_____
Current health problems_____
_____
Medications currently being taken_____
_____
Are you pregnant? ___Yes (___months) ___No Do you smoke? ___Yes ___No

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR PRESENTLY HAVE:

Heart Disease or Attack
Angina Pectoris
High Blood Pressure
Congenital Heart Lesions
Mitral Valve Prolapse
Pacemaker
Heart Surgery
Anemia
Stroke
Joint Replacement(s)_____
A.I.D.S./ A.R.C. / HIV Pos
Hepatitis Type_____
Liver Disease
Drug Addiction
Bleeding Problems
Epilepsy or Seizures
Glaucoma
Emphysema
Kidney Trouble
Allergies or Hives
Diabetes
Thyroid Disease
Hypoglycemia
Hyperglycemia
Headaches
Pain in Jaw Joints
Taking Bisphosphonate medication
Past chemo therapy

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS ?

Aspirin Local anesthesia Erythromycin Nitrous oxide Codeine Penicillin

What other medications or substances are you allergic to?_____
_____
Is there any other Medical or Dental information that you feel I should know about?

Consent: The undersigned hereby authorizes MAURY HAFERNIK, D.D.S. ("Doctor") and /or his staff to take x-rays, models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's needs. I also authorize Doctor to perform any and all forms of treatment and therapy that may be indicated. I also understand that the use of local anesthetic agents embodies certain risk.

_____ _____ _____
Patient signature Date Doctor signature