

# PERSONAL HISTORY QUESTIONNAIRE

PATIENT NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

Please describe the reason you came to our office: \_\_\_\_\_

When was your last dental visit and what services were performed? \_\_\_\_\_

Your name: \_\_\_\_\_ Name of spouse or parent: \_\_\_\_\_

Who recommended this office? \_\_\_\_\_ Date of birth: \_\_\_\_\_

Social Sec. #: \_\_\_\_\_ Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Home address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Are you covered by DENTAL INSURANCE? Yes \_\_\_ No \_\_\_ If YES, then please fill out the following information.

Name of insurance: \_\_\_\_\_ Group No. \_\_\_\_\_

Name of policy holder: \_\_\_\_\_ Birth date of policy holder: \_\_\_\_\_

Soc. Sec. No. of policy holder: \_\_\_\_\_ Employer of policy holder: \_\_\_\_\_

Name of 2<sup>nd</sup> insurance carrier : \_\_\_\_\_ Group No. \_\_\_\_\_

Name of 2<sup>nd</sup> policy holder: \_\_\_\_\_ Birth Date of 2<sup>nd</sup> policy holder: \_\_\_\_\_

SS# of 2nd policy holder: \_\_\_\_\_ Employer of 2nd pol. holder: \_\_\_\_\_

Contact in case of emergency: \_\_\_\_\_ Emergency Phone : \_\_\_\_\_

Name & address of your Physician : \_\_\_\_\_

## CONSENT TO RECORDS TRANSFER

I HEREBY AUTHORIZE DR. KEITH KONVALINKA AND HIS STAFF TO REQUEST THE TRANSFER OF RECORDS FROM ANY PREVIOUS DENTISTS OR PHYSICIANS, WHICH HE MAY DEEM PERTINENT AND USEFUL IN MY FUTURE TREATMENT. I FURTHER CONSENT TO THE RELEASE OF MY RECORDS FROM DR. KONVALINKA'S OFFICE TO ANY OTHER PRACTITIONER, SPECIALIST, OR OTHER REFERRED DENTIST, PHYSICIAN, THERAPIST, OR INSURANCE CARRIER THAT MAY HAVE REASONABLE NEED FOR SUCH RECORDS IN THE FUTURE. I UNDERSTAND THAT DR. KONVALINKA WILL ENDEAVOR TO MAINTAIN CONFIDENTIALITY OF ALL UNRELATED PERSONAL AND MEDICAL OR DENTAL INFORMATION, WHEN POSSIBLE. IF I HAVE ANY QUESTIONS ABOUT THIS CONSENT, I UNDERSTAND THAT DR. KONVALINKA OR HIS STAFF ARE AVAILABLE TO ANSWER THEM.

\_\_\_\_\_  
(signature of patient, parent, or guardian)

\_\_\_\_\_  
date

## HEALTH HISTORY

Have you had any serious general health problem in the last 5 years? Yes \_\_\_ No \_\_\_ If so, specify: \_\_\_\_\_

Date of last medical check-up: \_\_\_\_\_ Are you under a physician's care now? Yes \_\_\_ No \_\_\_

If so, for what? \_\_\_\_\_

What tablets, pills, or medications do you take (including aspirin, vitamins, etc.)? \_\_\_\_\_

### DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS:

	YES	NO		YES	NO
Rheumatic fever or heart disease .....	___	___	Diabetes .....	___	___
Heart murmur, joint replacement .....	___	___	Chemotherapy for cancer .....	___	___
Heart attack, arrhythmia, heart trouble ...	___	___	Radiation treatment .....	___	___
High blood pressure or stroke .....	___	___	AIDS or HIV .....	___	___
Pain in chest or shortness of breath .....	___	___	Venereal or sex transmitted diseases ..	___	___
Blood disorders, anemia .....	___	___	Cold sores or canker sores .....	___	___
Blood test with unusual result .....	___	___	WOMEN: Are you pregnant .....	___	___
Abnormal bleeding or healing .....	___	___	Any other problem not found above	___	___
Asthma, hay fever, sinusitis .....	___	___	Please specify, if yes: _____		
Fainting spells or seizures .....	___	___	_____		
Hepatitis, jaundice, liver disease .....	___	___	_____		
Arthritis, TMJ dysfunction .....	___	___	Are you sensitive or allergic to any of the following:		
Kidney, or urinary trouble .....	___	___	Penicillin___ Codeine___ Aspirin___		
Tuberculosis, or other lung disease .....	___	___	Antibiotics___ Anesthetics___ Other drugs___		
Persistent cough or cough up blood .....	___	___			

I HEREBY ATTEST THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE, AND THAT I REALIZE THAT ANY INACCURACY MAY JEOPARDIZE MY FUTURE TREATMENT. ALSO, I HEREBY AUTHORIZE DR. KEITH R. KONVALINKA, HIS STAFF, AND/OR WHOMEVER HE MAY DESIGNATE AS HIS ASSISTANT(S), TO PERFORM UPON ME (OR MY MINOR CHILD OR WARD, IF APPLICABLE) THE TREATMENT THAT HE AND I WILL DISCUSS AT THE TIME OF MY TREATMENT. IMPLICIT IN MY (OR MY CHILD) BECOMING A PATIENT OF DR. KONVALINKA IS CONSENT TO THE DIAGNOSTIC PROCEDURES SUCH AS X-RAYS, EXAMINATION, AND ANY ADDITIONAL PROCEDURES HE MAY DEEM NECESSARY TO ARRIVE AT A PLAN OF TREATMENT. I ALSO UNDERSTAND THAT IF ANY UNFORSEEN CONDITIONS ARISE IN THE COURSE OF TREATMENT CALLING, IN HIS JUDGEMENT, FOR EMERGENCY PROCEDURES IN ADDITION TO, OR DIFFERENT FROM THOSE NOW CONTEMPLATED, I FURTHER REQUEST AND AUTHORIZE HIM TO DO WHATEVER HE DEEMS ADVISABLE.

\_\_\_\_\_

(signature of patient, parent, or guardian)

\_\_\_\_\_

date