William C. Jaques, D.D.S.

Patient Questionnaire

Patient's Name _____Date of Birth _____Age_____
Address_____ City _____State _____Zip Code_____
Home Phone ( ) _____Cell Phone ( ) _____Work Phone ( ) _____
E-mail Address _____Marital status _____Spouse Name_____
Employer (Patient's) _____Patient's Social Security Number_____
Who is responsible for account? Self or_____ How did you hear about Dr. Jaques?_____

Dental Insurance

Name of Insured_____SSN_____Date of Birth_____
Name of Insurance Co._____ Phone #_____Group # _____
Insured's Employer_____ If Secondary, Name of Insured_____
SSN _____Date of Birth_____ Name of Ins. Co._____
Phone # _____ Group # _____Insured's Employer_____
As a courtesy, your insurance company will be billed for your re-imbursement. Full payment is due at the time of service.

Responsible Party (If under 18 or other party responsible for patient's account) information

Name_____Address_____Home phone ( ) _____
Responsible Party's Employer_____ Work Phone ( )_____ Cell Phone ( )_____
E-Mail Address_____ Responsible Party's Social Security Number_____

Patient Medical History

Are you in good health? Yes ( ) No ( ) Name of physician _____Telephone number ( ) _____
If no, please explain _____Date of last physical _____ Are you taking any medication now? (Y) (N)
If yes, names of medications: _____ Are you Allergic to any medications? (Y) (N)
If yes, names of medications: _____ Are you Allergic to Latex? (Y) (N)
Are you pregnant? (Y) (N) if yes, expected delivery date: _____ Do you smoke? (Y) (N) if yes, how much? ____
Have you ever experienced ill effects from a local anesthetic such as Novocain? (Y) (N) If yes, explain_____

Have you ever had any of the following? Please circle

AIDS or HIV+	Yes	No	High Blood Pressure	Yes	No
Anemia……	Yes	No	Kidney or Liver Diseases	Yes	No
Arthritis…	Yes	No	Nervous Disorders	Yes	No
Asthma……	Yes	No	Pacemaker	Yes	No
Blood transfusion, if yes date	Yes	No	Artificial Prosthesis	Yes	No
Circulatory problems…	Yes	No	Radiation Treatment, if yes, date _____	Yes	No
Diabetes	Yes	No	Rheumatic fever	Yes	No
Dizziness or Faintness	Yes	No	Sinus trouble	Yes	No
Epilepsy	Yes	No	Stroke, if yes, date _____	Yes	No
Headaches	Yes	No	Tuberculosis	Yes	No
Heart Attack, if yes date	Yes	No	Ulcers	Yes	No
Heart Murmur	Yes	No	Venereal Disease	Yes	No
Heart Trouble	Yes	No	Artificial Joints, if yes, what _____ yr. _____		No
Mitral Valve Prolapse	Yes	No	Please list other serious illnesses you have had:		
Artificial Heart Valves	Yes	No	_____		
Hepatitis A or B	Yes	No	Cancer, if yes, date _____		

The information given on this questionnaire is accurate to the best of my knowledge. I hereby grant my consent to perform evaluation of my dental health, administer diagnostic tests (including x-rays) and to perform treatment necessary.
*your signature indicates releasing William C. Jaques, D.D.S. to utilize any dental photographs for lecturing and educational purposes.

_____ _____
*Signature of patient, parent or guardian (if under 18) Date

Health History Questionnaire Update (office use only)

Date and Initials _____ _____ _____ _____ _____ _____