TEENAGER HEALTH QUESTIONAIRE

The data on this confidential questionnaire is essential to render the best professional care. We appreciate your co-operation in filling it out carefully, so that we will have accurate records. PLEASE PRINT. THANK YOU

PATIENT'S LAST NAME	**GIVEN NAMES**		**SEX**	**HOME PHONE**
APARTMENT / **ADDRESS**		**CITY**	**POSTAL CODE**	**HEALTH CARD NUMBER**
DATE OF BIRTH MONTH DAY YEAR	**ARE YOU A STUDENT?**	**NAME OF SCHOOL**		
IF YOU ARE WORKING GIVE OCCUPATION		**EMPLOYER**		
BUISNESS ADDRESS			**BUISNESS PHONE**	**LOCAL**
YOUR FATHER'S NAME	**HIS OCCUPATION**		**BUISNESS PHONE**	**LOCAL**
HIS EMPLOYER	**BUISNESS ADDRESS**			
YOUR MOTHER'S NAME	**HER OCCUPATION**		**BUISNESS PHONE**	**LOCAL**
HER EMPLOYER	**BUISNESS ADDRESS**			
NAME OF FAMILY MEMBER RESPONSIBLE FOR PAYMENT OF YOUR ACCT.	**WHOM MAY WE THANK FOR REFERING YOU TO THIS OFFICE?**			
DO YOU HAVE DENTAL INSSURANCE COVERAGE Y N	**NAME OF INSURING COMPANY**	**NAME OF ADMINISTRATIVE COMPANY (IF ANY)**		
PHYSICIAN or PEDIATRICIAN	**FAMILY DENTIST OR FORMER DENTIST**			

HAVE YOU EVER HAD ANY **Please CIRLCE the correct answers. GIVE DETAILS where indicated.**

- Serious Operations? No Yes ……
- Serious Illnesses? No Yes ……
- Rheumatic Fever? No Yes ……
- Heart, or Blood Pressure Problems? No Yes ……
- Lung, or Breathing Problems? No Yes ……
- Liver, or Kidney Problems? No Yes ……
- Stomach, or Intestinal Problems? No Yes ……
- Bleeding Tendencies? No Yes ……
- Anemia? No Yes ……
- Allergies- Hay fever? No Yes ……
  - Asthma? No Yes ……
  - Other? No Yes ……
- Drug reactions or allergies to:
  - Penicillin? No Yes ……
  - Aspirin? No Yes ……
  - Other Drugs? No Yes ……

Approximately when did you have your last physical examination
……
……

Asides from your regular checkups are you now under treatment by a physician? No Yes ……..
……

What medications are you taking now?……...
……

Is there anything else concerning your health that the doctor should know No Yes……..
……

DENTAL HISTORY

1. Are you seeking treatment for any particular reason and or routine dental care?
2. Has your child had previous dental care?……...
   ……
3. Has the child ever had an accident, injury or surgery about the mouth?……

OFFICE POLICY

Your appointment time will be reserved especially for you. **If you are unable to keep the appointment we will require 24 hours notice, otherwise it will be necessary to charge for this time lost**. **Office policy is that services are paid for each visit as they are performed**. However in certain circumstances consulting the business may make arrangements for payments assistant.

Please circle one of the following numbers.

1. I have dental insurance
2. I wish to pay each visit as the services are performed.
3. I wish to know the total fee for all the work to be done, to make special arrangements for payment as well as the number of appointments necessary so that I can pay equal portions at each appointment.

DATE: _____ **SIGNATURE:** _____