Alexander M. Mazratian, DDS, MEd

PRACTICE LIMITED TO PERIODONTICS **TELEPHONE (409) 898-2068**

HEALTH QUESTIONNAIRE

Name:______________________________ Age:_____ Birthdate: ____________Height________ Weight________
Home Street Address____Zip __________________
Mailing Address ____ Zip __________________
SS# ______ - ______-______ Home Phone: (____)________________Cell Phone: (____)______________________
Email Address: ____

Circle If You Are: Single Married Widowed Separated Divorced

Occupation:___________________ Employer:__________________________ Phone: (____)___________________
Spouse or parent Name: __________________________ SS#: ______-______-______ DOB: ___________________
Spouse or parent Phone : (___)______________ Occupation: _______________ Employer: _____________________
Person Responsible for Payment: ____
Insurance Carrier: ____

Please State The Reason For This Visit To Our office:____
By Whom Were You Referred To our office?____
Name of Present Dentist: ____________________ How Long Have You Been a Patient of Present Dentist?________

Relative or friend not living with you
His/Her Name:______________________________ Relation _____________________________________
Home Phone: (____)_________________________ Work Phone: (____)____________________________

DO YOU HAVE OR HAVE YOU HAD:

Aids/ Hiv-------------------------------------Yes No
ARC (Aids Related Complex)------------Yes No
Rheumatic Fever----------------------------Yes No
Rheumatic Heart Disease------------------Yes No
Diabetes--------------------------------------Yes No
Thyroid Problem----------------------------Yes No
Glaucoma---------------------------------- Yes No
Scarlet Fever---------------------------------Yes No
Tumor or Growth------------------------- Yes No
Cancer-------------------------------------- Yes No
Epilepsy, Convulsions or Seizures------ Yes No
Jaundice (Yellow Skin & Eye)----------- Yes No
High Blood Pressure--------------------- Yes No
Anemia or Abnormal Blood Counts---- Yes No
Hepatitis-------------------------------- Yes No
Tuberculosis-------------------------- Yes No
Liver Problems---------------------- Yes No
Kidney Problems--------------------- Yes No
Venereal Disease--------------------- Yes No
Pacemaker--------------------------- Yes No
Heart Attack or Heart Trouble------Yes No
Heart Murmur------------------------Yes No
Mitral Valve Prolapse----------------Yes No
Shortness of Breath-------------------Yes No
Excessive Thirst-----------------------Yes No
Frequent Urination--------------------Yes No
Artificial Bones/Joints/Valves-------Yes No
Osteoporosis/Osteopenia------------- Yes No

Please list any serious medical conditions / surgeries that you have or have had _______________________________
____

Do you suffer from or have ever had fever blisters or cold sores?____

Do you Smoke or Chew Tobacco? __________ Name of Pharmacy you currently use:_________________________

PLEASE CIRCLE ANY OF THE FOLLOWING MEDICATIONS YOU ARE ALLERGIC TO:

Penicillin	Carboncaine	Aspirin	Valium
Erythromycin	Xylocaine	Latex	Demerol
Tetracycline	Novocaine	Codeine	Morphine
Keflex	Nubaine	Tylenol	Barbiturates

Do You Have Any Allergies to Any Medications Not Listed Above?----------------------------------- **Yes No**
If Yes, Please List____
List Any Medication (Pills) You Are Currently Taking (**INCLUDING ASPIRIN, PLAVIX, OR ANY OTHER BLOOD THINNERS)**____
____
Are **you under the care of a pain management doctor or facility** Yes No Name________________________

____I understand that if I am diabetic or borderline diabetic the prognosis of any dental procedures maybe compromised.
____I understand that if I am taking Bisphosphonate Derivatives such as Boniva, Fosamex, etc. that I have a greater chance of Osteoneocrosis (bone infarction) or implant failure.

FOR FEMALES ONLY:

Are you pregnant?____ Yes No
Are you taking birth controls pills?_______________________________________ Yes No
Have you been through or are you going through menopause (Change of Life)______________ Yes No

DENTAL HISTORY

Have You Ever Had Periodontal Treatment Before? **Yes____ No____** When?______________________________

I understand that the information that I have given you today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I might need during diagnosis and treatment with my informed consent.

___________________________________ ___________________________
Signature Date

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT

(Unless prior arrangements have been approved.)

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all cost of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my
insurance company.

______________________________________ ______________________________
Signature Date

INSURANCE DIRECTIVE

Date: ________________
Patient: ____
Insurance Company: ____
SSN# / ID #: ____

Our office policy is to collect in full for all procedures. As a courtesy, we will file the insurance claim for our patients and have the insurance company reimburse the patient. By signing below, you are giving us the right to seek payment on your behalf, file and inquiry about claims on your behalf, and file complaints against the insurance company if needed.

A photocopy of this Directive shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Date:___________________________

______________________________ ____________________________
Signature of Policyholder Witness

____
Signature of Claimant, if other than Policyholder