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: (____)_____
Circle If You Are: Single Married Widowed Separated Divorced
Occupation:_____ Employer:_____ Phone: (____)_____
Spouse: _____ SS#: _____-_____-_____ DOB: _____
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**	Hepatitis_____	**Yes**	**No**
ARC (Aids Related Complex)_____	**Yes**	**No**	Tuberculosis_____	**Yes**	**No**
Rheumatic Fever_____	**Yes**	**No**	Liver Problems_____	**Yes**	**No**
Rheumatic Heart Disease_____	**Yes**	**No**	Kidney Problems_____	**Yes**	**No**
Diabetes_____	**Yes**	**No**	Venereal Disease_____	**Yes**	**No**
Thyroid Problem_____	**Yes**	**No**	Pacemaker_____	**Yes**	**No**
Glaucoma_____	**Yes**	**No**	Heart Attack or Heart Trouble_____	**Yes**	**No**
Scarlet Fever_____	**Yes**	**No**	Heart Murmur_____	**Yes**	**No**
Tumor or Growth_____	**Yes**	**No**	Mitral Valve Prolapse_____	**Yes**	**No**
Cancer_____	**Yes**	**No**	Shortness of Breath_____	**Yes**	**No**
Epilepsy, Convulsions or Seizures_____	**Yes**	**No**	Excessive Thirst_____	**Yes**	**No**
Jaundice (Yellow Skin & Eye)_____	**Yes**	**No**	Frequent Urination_____	**Yes**	**No**
High Blood Pressure_____	**Yes**	**No**	Artificial Bones/Joints/Valves_____	**Yes**	**No**
Anemia or Abnormal Blood Counts_____	**Yes**	No	Osteoporosis_____	**Yes**	**No**

Please list any serious medical conditions / surgeries that you have or have had _____
_____
Do you Smoke or Chew Tobacco? _____

PLEASE CIRCLE ANY OF THE FOLLOWING MEDICATIONSYOU 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**) _____
_____
_____
_____

FOR FEMALES ONLY:

Are You Pregnant?_____ **Yes** **No**
Are You Taking Birth Control 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

APPOINTMENT AGREEMENT
for the office of
ALEXANDER MAZRATIAN, DDS

At this office we strive to offer the best of care to all our patients. We understand that everyone's time is very valuable. If for some reason you can not make your scheduled appointment, we ask that you contact the office as soon as possible. This will allow us the opportunity to take your scheduled time and offer it to other patients needing to come in sooner. Therefore, in consideration for our patients and staff we require 24hr notice to reschedule appointments. Appointments that are broke without notice are a benefit to no one.

I understand that I am responsible for the payments of services rendered today. I also understand that I must pay any co-payments and deductibles that my insurance does not cover.

I agree to place a deposit down for recommended dental services of no less than $50.00. This money is a deposit to reserve my appointment time. This deposit is separate from the charges for the initial consultation fees. I understand this money will go towards money that is owed on my scheduled appointment. I further realize that should I break this appointment or any other appointments without 24hr. notice this money is forfeited. However, if I have to cancel my appointment and give at least a 24hr. notice, this money may be returned to me or credited to my account for future therapy without penalty at my request.

If I choose not to schedule an appointment today I am aware that at any time I can mail in the payment or return to the office and make the deposit and schedule the appointment.

I understand that this is the policy of this office and agree to the terms.

_____ Date_____
Patient/Guardian Signature

_____
Staff Signature