

John J. Haidet DDS MS
Louis W. Susi DDS MS
Daniel S. Stentz DDS MS
Daniel P. Magness DDS MS

145 Reynoldsburg-New Albany Road
Suite 100
Blacklick, Ohio 43004
614 577 1100 • cbusendo.com



Patient's Name: _____ Birth Date: _____

Patient's Home Address: _____ Home Phone: _____

City and Zip: _____ Work Phone: _____

Place of Employment: _____ Cell Phone: _____

Name of Spouse: _____ Where Employed: _____

Person Responsible for Patient's Account: _____

Name of Dental Insurance Company: _____

In Case of Emergency Contact: _____ Phone: _____

Name of Dentist Who Referred You: _____

HEALTH HISTORY

Name of Physician: _____ Date of Last Physical: _____

Please check (✓) any of the following diseases or problems which you have or have had:

- | | | |
|---|---|---|
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Thyroid Condition or Goiter | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Rheumatic Heart Disease | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Angina |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Emotional Difficulty | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> HIV infection/AIDS | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma or Hay Fever | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Hives or Skin Rash |
| <input type="checkbox"/> Epilepsy (fainting spells or seizures) | <input type="checkbox"/> Hepatitis, Jaundice or Liver Disease | <input type="checkbox"/> Joint Replacement |

Please check (✓) Yes or No for each question:

- Yes No 1. Are you in good health?
 Yes No 2. Are you under a physician's care?
 Yes No 3. Have you been hospitalized or had a serious illness within the last five years?
 Yes No 4. Have you ever had abnormal bleeding associated with previous extractions, surgery or trauma?
 Yes No 5. Have you had surgery or x-ray treatment for a tumor, growth or other condition of your mouth or body?

6. Have you had any of the following within the last 6 months?

- Yes No Antibiotics or Sulfa Drugs
 Yes No Anticoagulants (blood thinners)
 Yes No Medicine for Blood Pressure
 Yes No Cortisone Steroids
 Yes No Tranquilizers
 Yes No Nitroglycerin, or other Drugs for Heart Trouble
 Yes No Insulin or Oral Medication for Diabetes
 Yes No Medication for Osteoporosis
 Yes No Other Medication? _____

7. Are you ALLERGIC to any of the following?

- Yes No Local Anesthetics
 Yes No Penicillin or other Antibiotics
 Yes No Barbiturates, Sedatives or sleeping pills
 Yes No Aspirin or Codeine
 Yes No Iodine or Latex
 Yes No Other? _____

8. Women are you:

- Yes No Pregnant
 Yes No Breastfeeding
 Yes No Using Oral Contraceptives or hormonal therapy

9. Do you have any other disease, condition, or problem not listed above that you think we should know about? Yes No

Explain: _____

I certify that I have accurately answered the above questions to the best of my knowledge. I consent to the performance of dental procedures agreed to be necessary including the use of local anesthetic as indicated, and I will assume responsibility for fees with those procedures.

Signature: _____ SS# _____ Date: _____