

# PATIENT INFORMATION

## PATIENT

DATE \_\_\_\_\_

LAST NAME

FIRST NAME

MIDDLE NAME

ADDRESS

APT NO.

CITY

STATE

ZIP

SOC. SECURITY NO.

DATE OF BIRTH

MARITAL STATUS

AGE

HOME PHONE

CELL PHONE

EMPLOYER

OCCUPATION

EMPLOYER'S ADDRESS

BUSINESS PHONE

## SPOUSE, PARENT or GUARDIAN

LAST NAME

FIRST NAME

MIDDLE NAME

HOME PHONE

CELL PHONE

HOME ADDRESS (IF DIFFERENT THAN PATIENT)

CITY

STATE

ZIP

EMPLOYER

OCCUPATION

EMPLOYER'S ADDRESS

BUSINESS PHONE

## INSURANCE

PATIENT'S HEALTH INSURANCE PROVIDER

GROUP NO. ID NO.

PHONE NO.

WILL THIS CLAIM BE COVERED BY WORKER'S COMPENSATION?

YES \_\_\_\_ NO \_\_\_\_

IF YES, NAME OF INSURER

INSURER'S ADDRESS

INSURER'S PHONE NO.

TREATMENT AUTHORIZED BY

## OTHER INFORMATION

PATIENT'S DENTIST

PATIENT'S PHYSICIAN

PATIENT REFERRED TO THIS OFFICE BY

I have completed both sides of this form fully and completely, and I certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I understand that even if I have insurance coverage, I am responsible for payment for any and all services provided.

PREFERRED METHOD OF PAYMENT: CASH \_\_\_\_ CHECK \_\_\_\_ CREDIT CARD \_\_\_\_

DATE

SIGNATURE OF PATIENT, PARENT or RESPONSIBLE PARTY

GERALD ROTHMAN, DDS, LTD  
DIPLOMATE-ABOMS

JEFFREY ROTHMAN, DDS  
DIPLOMATE-ABOMS

ALEXANDRIA  
PROFESSIONAL CENTER

4660 KENMORE AVE., STE. 204  
ALEXANDRIA, VA 22304

TEL: 703 370-3012  
FAX: 703 370-6005

# HEALTH HISTORY

PATIENT'S NAME \_\_\_\_\_

DATE \_\_\_\_\_

**Please answer all questions by circling Yes (Y) or No (N). All responses are confidential.**

- |   |  |
|---|--|
| <p>1. Are you in good health? ..... Y N</p> <p>2. Has there been any change in your general health in the past year? ..... Y N</p> <p>3. Date of last physical exam _____</p> <p>4. Are you now under a physician's care for a particular problem or condition? ..... Y N</p> <p>5. Have you ever had any serious illnesses, operations or hospitalizations? If so, please describe ..... Y N<br/>         _____<br/>         _____</p> <p>6. <b>DO YOU HAVE OR HAVE YOU EVER HAD:</b></p> <p>a. Rheumatic Fever or Rheumatic Heart Disease? ..... Y N</p> <p>b. Congenital Heart Disease? ..... Y N</p> <p>c. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Heart Palpitations, Heart Surgery, Pacemaker) ? ..... Y N</p> <p>d. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Sever Coughing) ? Y N</p> <p>e. Seizures, Convulsions, Epilepsy, Fainting, Dizziness, Psychiatric Treatment or other Nervous Disorders? .... Y N</p> <p>f. Bleeding Disorder, Anemia, Bleeding Tendency or Blood transfusions? Do you bruise easily? ..... Y N</p> <p>g. Liver Disease (Jaundice, Hepatitis) ? ..... Y N</p> <p>h. Kidney Disease? ..... Y N</p> <p>i. Diabetes? ..... Y N</p> <p>j. Thyroid Disease (Goiter) ? ..... Y N</p> <p>k. Arthritis? ..... Y N</p> <p>l. Stomach Ulcers or Colitis ..... Y N</p> <p>m. Glaucoma? ..... Y N</p> <p>n. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee) ? ..... Y N</p> <p>o. Radiation (X-ray) treatment for Cancer? ..... Y N</p> <p>p. Sinus or Nasal problems? ..... Y N</p> <p>q. Any disease, drug or transplant operation that has depressed your Immune system? ..... Y N</p> <p>r. HIV, AIDS, or ARC? ..... Y N</p> <p>7. <b>ARE YOU USING ANY OF THE FOLLOWING?</b></p> <p>a. Antibiotics? ..... Y N</p> <p>b. Anticoagulants (Blood Thinners) ? ..... Y N</p> <p>c. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? .... Y N</p> <p>d. High Blood Pressure medications? ..... Y N</p> <p>e. Steroids (Cortisone, etc.) ? ..... Y N</p> <p>f. Tranquillizers? ..... Y N</p> | <p>g. Insulin or Oral Anti-Diabetic drugs? ..... Y N</p> <p>h. Digitalls, Inderal, Nitroglycerin or other heart medications? ..... Y N</p> <p>i. Any regular prescription medicine, pill, or drug? ..... Y N<br/>         If so, please list: _____<br/>         _____</p> <p>j. Herbal or Holistic remedies, Vitamins or over-the-counter medications? ..... Y N<br/>         If so, please list: _____<br/>         _____</p> <p>8. <b>ARE YOU ALLERGIC TO or HAVE YOU HAD AN ADVERSE REACTION TO:</b></p> <p>a. Local Anesthesia (Novocaine, etc.) ? ..... Y N</p> <p>b. Penicillin or other antibiotics? ..... Y N</p> <p>c. Sedatives, Barbiturates? ..... Y N</p> <p>d. Aspirin or Ibuprofen? ..... Y N</p> <p>e. Codeine or other pain killers? ..... Y N</p> <p>f. Latex or Rubber products? ..... Y N</p> <p>g. Other allergies or reactions? ..... Y N<br/>         If so, please list: _____<br/>         _____</p> <p>9. Do you smoke or chew tobacco? ..... Y N</p> <p>10. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that might affect the care we provide you? ..... Y N</p> <p>11. Have you had any serious problems associated with any previous dental treatment? ..... Y N</p> <p>12. Have your or an immediate family member had any problem associated with intravenous anesthesia? ..... Y N</p> <p>13. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? ..... Y N</p> <p>14. Do you wish to speak to the doctor privately about anything? ..... Y N</p> <p>15. <b>FEMALES ONLY</b></p> <p>a. Are you pregnant, or is there any chance that you might be pregnant? ..... Y N</p> <p>b. Are you nursing? ..... Y N</p> <p>c. If you are using Oral Contraceptives, it is important for you to understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.</p> |
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**I UNDERSTAND THE IMPORTANCE OF A TRUTHFUL HEALTH HISTORY TO ASSIST THE DOCTOR IN PROVIDING THE BEST CARE POSSIBLE. I HAVE HAD THE OPPORTUNITY TO DISCUSS MY HEALTH HISTORY WITH MY DOCTOR.**

SIGNATURE OF PERSON COMPLETING HEALTH HISTORY \_\_\_\_\_

DATE \_\_\_\_\_

DOCTOR'S INITIALS \_\_\_\_\_

**MEDICAL UPDATE: I HAVE READ MY HEALTH HISTORY DATED \_\_\_\_\_ AND CONFIRM THAT IT ACCURATELY STATES PAST AND PRESENT HEALTH CONDITIONS.**

EXCEPTIONS OR CHANGES \_\_\_\_\_

DATE \_\_\_\_\_

PATIENT'S SIGNATURE \_\_\_\_\_

DOCTOR'S INITIALS \_\_\_\_\_