HAZIM DENTAL CLINIC P.C.
Ziad A. Hazim DDS
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GENERAL HEALTH INFORMATION

Patient

Full Name:				Date:	
	Last	*First*	*Middle*		
SSN:	- -	DOB:		Age:	

Dental History

Reason for today's visit? ☐ Check-up ☐ Cleaning ☐ Toothache ☐ Other:

When did you last visit a dentist? ________ What treatment was performed? ________

Are you allergic or reactive to dental Anesthetic (Novocain)? ☐ Yes ☐ No ☐ Don't know

How often do you brush your teeth? ________ Floss? ________

Have you ever had any trouble with past dental treatment? ☐ Yes ☐ No If yes, please specify:

Have you ever been told you have gum disease? ☐ Yes ☐ No If yes, please specify:

Please check any of the following treatments you have had and list date:
☐ Orthodontic treatment (braces) ☐ Periodontal (gum) therapy ☐ Oral surgery of any kind

Do you have any popping, clicking, locking or pain in the jaw (TMJ)? ☐ Yes ☐ No ☐ Don't know

Have you ever had excessive bleeding following cuts or extractions? ☐ Yes ☐ No ☐ Don't know

Medical History

Are you under a Doctor's care at this time? ☐ Yes ☐ No If yes, please specify:________________________________

Dr. Name: ________ Dr. Phone: ________ Dr. City: ________

Have you been hospitalized in the last 2 years? ☐ Yes ☐ No If yes, please specify:____________________________

Do you smoke? ☐ Yes ☐ No Do you drink alcohol? ☐ Yes ☐ No Do you use drugs? ☐ Yes ☐ No

Are you taking any medications at this time, including birth control? ☐ Yes ☐ No If yes, please specify: ______________________________________

(Woman) Are you pregnant? ☐ Yes ☐ No If yes, when is your due date? ______________________________________

Present medications, if any? ________

Medications allergic to, if any? ________

Please check if you have, or had, any of the following?

Condition			Condition			Condition		
Artificial Heart Valve	☐ Yes	☐ No	Fainting	☐ Yes	☐ No	Lung Disease	☐ Yes	☐ No
AIDS/HIV+	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Heart Attack	☐ Yes	☐ No	PHEN-FEN	☐ Yes	☐ No
Angina	☐ Yes	☐ No	Heart Surgery	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Bleeding Problems	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Sleep Apnea	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Smoking Tobacco	☐ Yes	☐ No
Chemo/RAD Therapy	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Joint Replacement	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Dizzy Spells	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	TMD or TMJ	☐ Yes	☐ No
Drug Addiction	☐ Yes	☐ No	Latex Allergy	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Liver Problems	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	None of the Above	☐ Yes	☐ No

Patient Signature

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I further certify that I consent to taking x-rays and an oral examination.

Signature of Responsible Party or Patient:		Date:	
Doctor's Signature:		Date:	