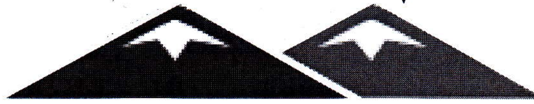
TIMBERLINE DENTAL, PLLC



FLAGSTAFF
518 North Beaver St., #A
Flagstaff, Arizona 86001
(928) 774-4705

WILLIAMS
401 W. Railroad Avenue
Williams, Arizona 86046
(928) 856-2100

1) How did you hear about us? ____________________
2) Reason for visit? ____________________
3) When was your last visit to a Dentist? ____________________
4) Are you having pain or discomfort at this time? .... ❑ Yes ❑ No
5) Do you feel very nervous about having dental treatment? .... ❑ Yes ❑ No
6) Have you ever had a bad experience in a dental office? .... ❑ Yes ❑ No
7) Have you been under the care of a physician during the last two years? .... ❑ Yes ❑ No
   Physician's Name ____________________
   Address ____________________
   Phone Number ____________________
8) Are you now taking any medications, drugs, pills or use tobacco? .... ❑ Yes ❑ No
   If yes, please list ____________________
9) Are you allergic to or have you reacted adversely to any medications or substances?

❑ Yes	❑ No	Aspirin	❑ Yes	❑ No	Codeine	❑ Yes	❑ No	Other
❑ Yes	❑ No	Penicillin	❑ Yes	❑ No	Erythromycin	If yes, please list ______		
❑ Yes	❑ No	Local Anesthetic	❑ Yes	❑ No	Latex			

10) Have you ever been a patient in a hospital? .... ❑ Yes ❑ No
   If yes, indicate procedures performed ____________________
11) Have you in the past or do you currently have:

❑ Yes	❑ No	Heart Disease/Attack	❑ Yes	❑ No	Epilepsy or Seizures	❑ Yes	❑ No	TMJ Treatment
❑ Yes	❑ No	High Blood Pressure	❑ Yes	❑ No	Hemophilia	❑ Yes	❑ No	Diabetes
❑ Yes	❑ No	Heart Murmur	❑ Yes	❑ No	Artificial Joints	❑ Yes	❑ No	Psychiatric Treatment
❑ Yes	❑ No	Rheumatic Fever	❑ Yes	❑ No	Venereal Disease	❑ Yes	❑ No	HIV+
❑ Yes	❑ No	Heart Surgery	❑ Yes	❑ No	Kidney Disease	❑ Yes	❑ No	Hepatitis (A, B, C)
❑ Yes	❑ No	Mitral Valve Prolapse	❑ Yes	❑ No	Pain in Jaw Joints	❑ Yes	❑ No	Drug Addiction

12) Do you have any disease, condition or problem that is not listed? .... ❑ Yes ❑ No
   If yes, please describe ____________________
13) For women only:
   Are you taking birth control pills? .... ❑ Yes ❑ No
   Are you pregnant? .... ❑ Yes ❑ No
   If yes, what month? ____________________

CONSENT:

To the best of my knowledge, the above information on this Health History sheet is as complete and accurate as possible. I understand that without full and accurate information the Doctor may not be able to provide me with the best care possible.

I hereby authorize the Doctor to take radiographs (X-rays), study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of my dental needs. Also, by presenting myself for treatment, I authorized the Doctor to perform any and all forms of treatment, medication & therapy, that may be indicated and further authorized and consent that the Doctor choose and use such assistance as he/she deems fit.

____________________ Date ____________
Signature of Patient or Responsible Party

Health History reviewed by Doctor ____________ Date ____________

Health History reviewed by Doctor ____________ Date ____________

Health History reviewed by Doctor ____________ Date ____________