Raymond R. Copeland, D.D.S., Ltd.

Diplomate of American Board of Endodontics
Practice Limited to Endodontics

Health Questionnaire

So that we might better serve you, kindly answer the following confidential questions.

Date _____

Name _____

Residence Address _____

City / State / Zip _____

Date of Birth _____ ❑ Single ❑ Married ❑ Other _____

Email _____

Social Security # _____ Home Phone _____

Occupation _____ Cell Phone _____

Employer _____ Business Phone _____

Business Address _____

City / State / Zip _____

Person Responsible for Account _____ Relationship _____

Spouse's Employer _____ Business Phone _____

Dental Insurance Co. _____

Whom may we thank for referring you to this office? _____

HEALTH QUESTIONS

Is your general health good?	❑ Yes	❑ No
Are you under a physician's care now?	❑ Yes	❑ No
Have you ever had ❑ Heart Trouble ❑ Rheumatic Fever ❑ Diabetes ❑ Infectious Hepatitis ❑ Mitral Valve Prolapse?	❑ Yes	❑ No
Have you ever tested positive for HIV?	❑ Yes	❑ No
Are you currently taking daily aspirin therapy?	❑ Yes	❑ No
Have you ever had trouble with bleeding?	❑ Yes	❑ No
Have you ever had an unusual reaction to any drug or medication?	❑ Yes	❑ No
Have you ever had an unusual reaction to local anesthetic?	❑ Yes	❑ No
Do you have allergies?	❑ Yes	❑ No
Are you presently taking any drug or medication?	❑ Yes	❑ No
Are you taking or have you ever taken medications for osteoporosis?	❑ Yes	❑ No
Are you pregnant?	❑ Yes	❑ No
Is there any other information about your health which should be known?	❑ Yes	❑ No

*Please describe on reverse side any current medical treatment, including drugs, impending operations, pregnancies or other information of which the doctor should be aware.

(over)

INSURANCE INFORMATION

Name of Insured _____

Dental Insurance Co. _____

Group or Policy No. _____

Social Security No. _____

Birthdate _____

PREFERRED PHARMACY

I authorize Raymond R. Copeland, DDS, Ltd., to electronically submit prescriptions. Please Initial _____.

Name of Pharmacy _____

City/Street _____

CURRENT MEDICAL TREATMENT (see other side*)

_____

_____

_____

_____

_____

_____

_____

_____

CONSENT

The undersigned hereby authorizes Doctor to take X-rays or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with that diagnosis. I further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand that the use of anesthetic agents embodies certain risks including allergic reactions, temporary paresthesia (numbness) and very rarely permanent paresthesia. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, and is due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance charge (12% annually) will be added to any balance over 60 days. In the event of default, I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Signature _____

Parent or Responsible Party _____

Relationship to Patient _____

Office Use Only

Witness _____ Date _____