



**ADULT HEALTH & BUSINESS QUESTIONNAIRE**  
 (Confidential information necessary for your files and your health)

Today's Date \_\_\_\_\_

Patient's Name (last) \_\_\_\_\_ (first) \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_

Home # \_\_\_\_\_ Cell # \_\_\_\_\_ E-mail \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Postal Code \_\_\_\_\_

Previous Address \_\_\_\_\_  
 (if less than 2 yrs)

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Work # \_\_\_\_\_

Nearest Relative/Spouse \_\_\_\_\_ Relationship: \_\_\_\_\_ Home # \_\_\_\_\_  
 (if other than spouse)

Address \_\_\_\_\_ City \_\_\_\_\_ Postal Code \_\_\_\_\_  
 (if different from Patient)

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Work # \_\_\_\_\_

Dentist \_\_\_\_\_ Physician \_\_\_\_\_

1. Are you in good health?..... YES NO

2. Are you currently under the ongoing care of a physician for a specific condition?..... YES NO

If Yes, explain: \_\_\_\_\_

3. Have you ever been hospitalized or had a serious illness or accident?..... YES NO

If Yes, explain: \_\_\_\_\_

4. Are you presently taking any medicine?..... YES NO

5. Please circle any of these drugs you have ever taken:

Penicillin	Blood thinners	Digitalis
Cortisone	Tranquilizers	Thyroid
Nitroglycerin	Dilantin	Aspirin
Ibuprofen	Other _____	_____

6. Please circle any of the items below that you have ever a bad reaction to:

Local Anesthetics	Codeine	Insulin	Barbituates	LATEX
Aspirin	Penicillin	Iodine	Metals: _____	Other _____

7. Please circle any illness you have ever had:
- |               |                 |                            |
|---------------|-----------------|----------------------------|
| Anemia        | Tuberculosis    | Inflammatory Rheumatism    |
| Allergies     | Epilepsy        | Kidney or Liver disease    |
| Asthma        | Glaucoma        | Rheumatic Fever            |
| Diabetes      | Fainting Spells | High or low blood pressure |
| Heart Trouble | Other _____     | _____                      |
8. Do you suffer frequent colds?..... YES NO
9. Do you have difficulty breathing through your nose?..... YES NO
10. Have you ever had abnormal bleeding associated with previous extractions, surgery or trauma?..... YES NO
11. Have you ever had an injury to the head, neck, face or chin? ..... YES NO
12. Is there any other information I should know about your health or previous dental treatment?..... YES NO
- If Yes, explain: \_\_\_\_\_
13. (Women ) Are you pregnant? ..... YES NO
14. Do you have a metal or latex sensitivity?..... YES NO
15. What is your main reason for seeking orthodontic care?\_\_\_\_\_
16. Have you previously or do you currently wear an appliance for jaw joint issues? ..... YES NO

**INSURANCE INFORMATION**

Subscriber \_\_\_\_\_ (2) \_\_\_\_\_

Insurance Company \_\_\_\_\_

Group/Policy \_\_\_\_\_

I.D./Cert.No \_\_\_\_\_

Subscriber's DOB. \_\_\_\_\_

**ACCOUNTING INFORMATION**

Person responsible for payment of account if different from patient:

Name: \_\_\_\_\_

Last	Given Name	Relationship
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Address: \_\_\_\_\_ Phone # \_\_\_\_\_

\_\_\_\_\_ Postal Code \_\_\_\_\_

Previous Address: \_\_\_\_\_  
(if less than 2 Yrs)

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Work # \_\_\_\_\_

ANSWERS TO ALL QUESTIONS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Financing with Dr. Leigh Harfield Professional Corporation is available on approved credit. I understand and consent to such pre-approval when and if payment plans are arranged.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_