JACK OHANESIAN DDS
FAMILY DENTISTRY

Health History Information

Your current physical health is ____Good ____Fair ____Poor

Are you taking any prescription/over-the-counter medications? If so, please list:_____

Have you ever had an unfavorable reaction to previous dental treatment? ____Yes ____No

For Women: Are you pregnant? ____Yes ____No Are you nursing? ____Yes ____No

Have you ever had any of the following?

(Please circle your answer)

Yes No AIDS
Yes No Allergic reactions to any over-the-counter/prescription medications. If so, please list:_____
Yes No Anemia
Yes No Artificial Heart Valve
Yes No Artificial Joints
Yes No Asthma
Yes No Blood Diseases
Yes No Cancer
Yes No Chemical Dependency
Yes No Chemotherapy
Yes No Diabetes
Yes No Epilepsy
Yes No Heart Murmur
Yes No Hemophilia
Yes No Hepatitis Type:_____ Year_____
Yes No High Blood Pressure
Yes No H.I.V. Positive
Yes No Liver Disease
Yes No Mitral Valve Prolapse
Yes No Pacemaker
Yes No Psychiatric Care
Yes No Radiation Treatment
Yes No Respiratory Disease
Yes No Rheumatic Fever
Yes No Tuberculosis

I understand that dentistry is not an exact science, and that therefore reputable practioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding dental treatment which I have requested and authorized. I consent for doctors or staff to perform dental treatment deemed necessary. I also understand and agree that regardless of insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on both pages of this “Patient Information and Health History” form and have completed all of the answers. I certify that this information is true and correct to the best of my knowledge. I will notify this office of any changes in my health status or any of the information on this form.

Signature of Patient (or authorized person, if patient is a minor)_____Date_____

HEALTH HISTORY UPDATES:

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