

Personal Information-Health History

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NAME _____ Birthday: _____ Social Security # _____

Mailing Address _____ City, State and Zip Code _____

HOW OR WHO REFERRED YOU TO OUR OFFICE? _____

PHONES: Work: _____ Home: _____ FAX: _____

Cell: _____ Pager: _____ Email: _____

OCCUPATION: _____ **EMPLOYER & address** _____

Dental Insurance: Name of Ins. Company: _____ Telephone Number : _____

Are you the primary policy holder Yes No If No please enter policy holders information below

Spouse's **OCCUPATION** _____ **EMPLOYER & address** _____

ACCOUNT RESPONSIBILITY if someone other than yourself: Name: _____

Their Social Security No.: _____ Birthday : _____

Mailing Address: _____ Daytime Phone _____

HEALTH HISTORY (please check if you have or had any of the following:)

<input type="checkbox"/> Yes <input type="checkbox"/> No Are you in good health?	<input type="checkbox"/> Yes <input type="checkbox"/> No Psychiatric care
<input type="checkbox"/> Yes <input type="checkbox"/> No Has your health changed in the last year	<input type="checkbox"/> Yes <input type="checkbox"/> No Kidney or bladder disease
<input type="checkbox"/> Yes <input type="checkbox"/> No Chest pain, shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No VD, herpes
<input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding problems, bruise easily	<input type="checkbox"/> Yes <input type="checkbox"/> No HIV positive, AIDS, ARC
<input type="checkbox"/> Yes <input type="checkbox"/> No Headaches, ringing in ears	<input type="checkbox"/> Yes <input type="checkbox"/> No Pregnant: month _____
<input type="checkbox"/> Yes <input type="checkbox"/> No Joint pain or stiffness, arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No Birth control Pills
<input type="checkbox"/> Yes <input type="checkbox"/> No Fainting or seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No Recreational drugs smoking/ alcohol
<input type="checkbox"/> Yes <input type="checkbox"/> No Heart disease, murmurs, rheumatic fever, prosthetic heart valve	<input type="checkbox"/> Yes <input type="checkbox"/> No Frequent/Heavy Snoring
<input type="checkbox"/> Yes <input type="checkbox"/> No Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No Significant daytime drowsiness
<input type="checkbox"/> Yes <input type="checkbox"/> No High Blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No Been told you stop breathing while sleeping
<input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis or liver disease	<input type="checkbox"/> Yes <input type="checkbox"/> No Gasp at times when waking up
<input type="checkbox"/> Yes <input type="checkbox"/> No TB, emphysema or lung disease	<input type="checkbox"/> Yes <input type="checkbox"/> No Feel unrefreshed in the morning
<input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No Have morning Headaches
<input type="checkbox"/> Yes <input type="checkbox"/> No Tumors, cancer	
<input type="checkbox"/> Yes <input type="checkbox"/> No Radiation treatment	

List any and all **ALLERGIES:** _____

List any and all **DRUGS/MEDICATIONS** you are taking: _____

List any and all **SURGERIES:** _____

Yes No Are you being treated by a Doctor now? Who? _____

The above information is true and correct to the best of my knowledge:

PATIENT SIGNATURE: _____ DATE: _____