

FIRST CHOICE DENTAL CENTER

DENTAL HEALTH QUESTIONNAIRE

Name _____ Birth date _____

*The following questions are very important to you, the dentist, and her staff. These questions are intended for therapeutic reasons only and the answers are **confidential**. However, they may be shared with subsequent treating dentists or physicians.*

HIV (AIDS)

- a. Have you ever tested positive for HIV?Yes No
- b. Do you have any reason to believe that you are at risk of being HIV positive?Yes No

Risk Factors

1. Needle drug use or sharing needles for drug or steroid use.
2. unprotected sex
3. received a blood transfusion or clotting factor during 1978 - 1985

These questions are important for your welfare. If your immune system is depressed, then the necessary antibiotic therapy must be more stringent than if your immune system is healthy. Please help us to provide you with the best dental care possible. If you have any questions, please feel free to ask the dentist.

Thank You

Patient Signature

Date

Doctor Signature

Date