

WELCOME TO OUR PRACTICE!

Thank you for choosing our office for your dental needs. Please take a few minutes to complete this confidential questionnaire so we may better serve you.

Date _____ / _____ / _____ Patient SS # _____ - _____ - _____
Name _____ Birth date _____ / _____ / _____ Sex: M or F
Address _____ City _____ State _____ Zip _____
Please check one: Single Married Separated Divorced Widowed

BILLING INFORMATION

Billing Name: _____ Self Spouse Parent Other _____
Billing Address (if different than home address) _____
City _____ Zip _____ Phone # at billing address (_____) _____ - _____

CONTACT INFORMATION

Home (_____) _____ - _____ Work (_____) _____ - _____ Cell (_____) _____ - _____ Other (_____) _____ - _____
Spouse Work (_____) _____ - _____ Spouse Cell (_____) _____ - _____
Email Address: _____ Emergency Phone (_____) _____ - _____ Relationship to Patient _____

INSURANCE INFORMATION

Insurance Company Name: _____ Group/ Policy Number: _____
Address _____ City _____ State _____ Zip _____
Employer: _____ Employee: _____
Employee SS # _____ - _____ - _____ Employee DOB _____ / _____ / _____
Do you have secondary coverage? Yes No (If yes, please provide information to a receptionist.)
Relationship to Patient: Self Spouse Child

How did you learn about our office? _____ Preferred appointment day/ time: _____

HEALTH HISTORY

It is important that we know about your medical and dental history. These facts have a direct bearing on your dental health.

What prompted you to seek dental care at this time? _____

Are you having any pain, discomfort or sensitivity at this time? If yes, please explain. _____

Are you nervous about receiving treatment? _____

Do you clench or grind your teeth? _____

Do you have pain in or around your jaw joints? If yes, please explain. _____

Have you been under the care of a medical doctor within the past two years? _____

PHYSICIAN'S NAME _____ PHONE (_____) _____ - _____ OFFICE LOCATION _____

Other Attending Physicians _____

**TO THE BEST OF YOUR KNOWLEDGE, HAVE YOU EVER HAD OR HAVE YOU NOW:
(IF YES, PLEASE CIRCLE SPECIFIC CONDITION/S)**

< BLOOD >		YES	NO	< INFECTIOUS DISEASES >		YES	NO
1	BLOOD DISEASES			34	GONORRHEA		
2	ANEMIA			35	SYPHILLIS		
3	BLEEDING GUMS			36	TUBERCULOSIS		
4	EXCESS BLEEDING FOLLOWING A CUT, TOOTH EXTRACTION, ETC			37	H.I.V.		
5	FREQUENT INFECTION			38	HEPATITIS OR JAUNDICE		
< BONES AND JOINTS >				39	HERPES		
6	ARTHRITIS OR RHEUMATISM			< NERVOUS SYSTEM >			
7	FREQUENT FRACTURES			40	NERVOUS OR MENTAL DISORDER		
8	JOINT PROSTHESIS/ ARTIFICIAL HIP			41	EPILEPSY, CONVULSIONS OR FAINTING		
9	SWOLLEN OR PAINFUL JOINTS			42	NEURITIS, NEURALGIA, OR NUMBNESS		
< CARDIOVASCULAR SYSTEM >				< RESPIRATORY SYSTEM >			
10	HEART TROUBLE			43	RESPIRATORY DISEASE		
11	PAIN OR PRESSURE IN CHEST			44	CHRONIC STUFFY NOSE		
12	RHEUMATIC FEVER-HEART MURMUR			45	ASTHMA, HAYFEVER, OR ALLERGIES		
13	MITRAL VALVE PROLAPSE			46	HALITOSIS (BAD BREATH) PROBLEM		
14	SOAKING SWEATS WITH PROLONGED FEVER			47	CHRONIC COUGH, HOARSENESS OR SORE THROAT		
15	HIGH OR LOW BLOOD PRESSURE			48	BRONCHITIS OR EMPHYSEMA		
16	SHORTNESS OF BREATH			49	DIFFICULTY BREATHING		
17	FREQUENT NOSE BLEEDS			< OTHER >			
18	STROKE			50	TUMORS, GROWTHS, CYST OR CANCER		
< ENDOCRINE >				51	RECENT GAIN OR LOSS OF WEIGHT		
19	THYROID, CORTISONE OR HORMONE TREATMENT			52	SCARLET FEVER, PNEUMONIA, OR ANY OTHER HIGH FEVER		
20	DIABETES			53	MUMPS		
21	FAMILY MEMBERS WITH DIABETES			54	HAVE YOU TAKEN DIET MEDICATION ?		
22	DRY OR BURNING MOUTH			55	SERIES OF NEEDLES OR INJECTIONS		
23	DRY OR SWEATING SKIN			56	OPERATIONS OR HOSPITALIZATIONS		
24	WEAKNESS OR SLEEPINESS			57	TOBACCO USE (_____ PACKS/DAY)		
< GASTROINTESTINAL SYSTEM >				58	ALCOHOL ABUSE		
25	STOMACH OR INTESTINAL TROUBLE			59	DRUG ABUSE		
26	FREQUENT INDIGESTION, DIARRHEA, OR VOMITING PROBLEM			60	REACTION TO PENICILLIN, OTHER ANTIBIOTICS OR ANESTHESIA		
27	APPETITE PROBLEM OR DIFFICULTY IN SWALLOWING			61	HAVE YOU RECEIVED ANY TRANSFUSIONS?		
28	LIVER TROUBLE, GALLBLADDER TROUBLE OR STONES			62	SKIN RASH, HIVES OR OTHER SKIN PROBLEMS		
29	ULCERS			63	SENSITIVITY OR ALLERGY TO LATEX		
< GENITOURINARY SYSTEM >				64	ARE YOU PREGNANT ?		
30	KIDNEY DISEASE			< SPECIAL ORGANS >			
31	SWOLLEN ANKLES OR EYELIDS			65	FACIAL INJURIES OR TOOTHACHES		
32	BURNING OR PAIN IN URINATION			66	EAR, EYE, NOSE OR THROAT PROBLEM		
33	FREQUENT URINATION			67	SINUSITIS OR HEADACHES		

IMMUNOSUPPRESSIVE CONDITION (CHECK ALL THAT APPLY)

- STEROID THERAPY ORGAN TRANSPLANT RADIATION OR CANCER THERAPY SLE (LUPUS)
 RHEUMATOID ARTHRITIS HIV NO SPLEEN FUNCTION OTHER _____

ALLERGIES (CHECK ALL THAT APPLY)

- LATEX PENICILLIN ASPIRIN CODEINE LOCAL ANESTHETICS OTHER _____

DO YOU HAVE ANY DISEASE, CONDITION, OR PROBLEM NOT LISTED? IF YES, PLEASE EXPLAIN.
