Patient Information

Email: **Cell #:** **Date**

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable lows. Please note that you will be asked about responses to this questionnaire and there may be additional questions concerning your health. This information is vital and to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: Home Phone: ( ) Work Phone: ( )

Address: City: State: Zip:

Mailing address

Occupation: Height: Weight: Date of Birth: Sex: M F

SS# Emergency Contact: Relationship: Home Phone: ( ) Cell Phone: ( )

If you are completing this form for another person, what is your relationship to that person?

Your Name Relationship

Whom may we thank for referring you to our practice? Or how did you hear about us?

Dental Insurance

Name of Insured: Date of Birth: Relation to patient:

SSN or Member ID #: Employer:

Insurance Company: Group #: Phone #: ( )

Medical Insurance

Name of Insured: Date of Birth: Relation to patient:

SSN or Member ID #: Employer:

Insurance Company: Group #: Phone #: ( )

What is the reason for your dental visit today? Please be as specific as possible.

Is there anything you would like to change about your smile or dental health?

Date of your last dental exam: Date of last dental x-rays:

What was done at that time?

Reason for leaving previous dentists

Dental Information Please check yes or no.

Yes	No	
❒	❒	Do your gums bleed when you brush or floss?
❒	❒	Are your teeth sensitive to cold, hot, sweets or pressure?
❒	❒	Is your mouth dry?
❒	❒	Have you had any periodontal (gum) treatments?
❒	❒	Have you ever had orthodontic (braces) treatment?
❒	❒	Do you have earaches or neck pains?
❒	❒	Do you brux or grind your teeth?
❒	❒	Do you have sores or ulcers in your mouth?
❒	❒	Do you wear dentures or partials?
❒	❒	Do you participate in active recreational activities?
❒	❒	Have you ever had a serious injury to your head or mouth?
❒	❒	Do you have any clicking, popping or discomfort in the jaw?
❒	❒	Have you had any problems associated with previous dental treatment?
❒	❒	Are you currently experiencing dental pain or discomfort?(If yes, please explain below.)

_____

_____

Medical Information

Allergies: Please check yes or no to any allergies you have. To all **yes** responses please specify what you are allergic to, type and severity of reaction. (Use the back of this form for additional space.)

Yes	No		Yes	No		Yes	No		Yes	No	
❒	❒	Local Anesthetics	❒	❒	Sulfa Drugs	❒	❒	Aspirin	❒	❒	Codeine or other narcotics
❒	❒	Antibiotics	❒	❒	Metal	❒	❒	Iodine	❒	❒	Barbiturates
❒	❒	Hay fever/Seasonal	❒	❒	Animals	❒	❒	Food	❒	❒	Sedatives or sleeping pills
❒	❒	Latex (rubber)	❒	❒	Other						

_____

_____

_____

Do you wear contact lenses?_____

Do you use controlled substances (drugs)?_____

Do you use tobacco (smoking, snuff, Chew, Bidis)? _____

If so, how interested are you in stopping? *Circle one*: Very / Somewhat / Not interested

Do you drink alcoholic beverages?_____

If yes, how much did you drink in the last 24 hours?_____

If yes, how much do you typically drink in a week?_____

Are you now under the care of a physician?_____ Physician Name_____

Date of last physical exam_____ Is your health good?_____

If, no please explain?_____

Has there been any change in your health within the past year?_____

If yes, please explain._____

Have you had a serious illness, operation or been hospitalized in that past 5 years?_____

If yes, please explain?_____

Are you taking or have you recently taken any prescription or over the counter medicine?_____

If yes, please list all, including vitamins, natural or herbal preparation on/or dietary supplements:

_____

_____

_____

Medical Information **Please check yes or no to indicate whether you have had or have any of the following conditions or diseases.**

Yes	No	
❒	❒	Artificial heart valve
❒	❒	Angina
❒	❒	Arteriosclerosis
❒	❒	Chest Pain
❒	❒	Congestive heart failure
❒	❒	Congenital heart defects
❒	❒	Damaged heart valves
❒	❒	Heart attack
❒	❒	Heart disease
❒	❒	Heart murmur/MVP
❒	❒	Heart surgery
❒	❒	Low blood pressure
❒	❒	High blood pressure
❒	❒	High Cholesterol
❒	❒	Pacemaker
❒	❒	Previous infective endocarditis
❒	❒	Rheumatic Fever/Heart Disease
❒	❒	Abnormal Bleeding/Anemia/hemophilia
❒	❒	Blood Transfusion-Date_____
❒	❒	AIDS/HIV Infection
❒	❒	Arthritis/Rheumatoid Arthritis
❒	❒	Any Autoimmune disease
❒	❒	Lupus/Erythematosus
❒	❒	Asthma/Bronchitis/Emphysema
❒	❒	Tuberculosis

Yes	No	
❒	❒	Cancer/Chemotherapy/Radiation
❒	❒	Chronic Pain
❒	❒	Diabetes
❒	❒	Excessive urination
❒	❒	Glaucoma
❒	❒	Eating disorder/Malnutrition
❒	❒	Gastrointestinal Issues/Ulcers
❒	❒	Stomach Problems
❒	❒	Hepatitis or Liver disease
❒	❒	Kidney problems of any kind
❒	❒	Thyroid Problems
❒	❒	Stroke
❒	❒	Seizures or Epilepsy
❒	❒	Osteoporosis
❒	❒	Sleep Disorder/Snoring/Sleep Apnea
❒	❒	Swollen Glands in Neck
❒	❒	Sinus Problems
❒	❒	Headaches or Migraines
❒	❒	Neck Pain
❒	❒	Recurrent Infections _____
❒	❒	Mental Disorders _____
❒	❒	Neurological Disorders _____
❒	❒	Night sweats
❒	❒	Weight loss/gain

Do you or have you had multiple myeloma or metastatic cancer?
Date treatment began:_____

Joint Replacement: Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?
Date:_____If yes, have you had any complications?_____

Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax, Actonel, Atelvia, Bonivia, Reclast, Prolia) for osteoporosis or Paget's disease? _____

Since 2001, were you treated or are you presently scheduled to begin taking an antiresorptive agent (like Aredia, Zometa, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease?_____

Has a physician or previous dentists recommended that you take antibiotics prior to your dental treatment?
Name of physician or dentist making recommendation_____
Phone number: (____)_____

Do you have any disease, condition, or problem not listed above that you think I should know about?
Please explain:_____

WOMEN ONLY: Are you pregnant?_____ Are you nursing? _____ Are you using birth control pills or hormone replacement therapy?_____

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

- We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the care coordinator. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, interest charges and any other expenses incurred in collecting your account.
- I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

_____

Print name

_____

Signature of Patient/Legal Guardian **Date**

_____

Relation to Patient

Reviewed by Doctor: _____