Patient Questionnaire

Restorative Dentistry & Dental Specialties

HEALTH HISTORY

To our patients: To help us meet your health needs, please complete this form. Your answers are for our records only and will be considered confidential.

Patient Name: _____ Date of Birth: _____

Primary Care Physician: _____ Telephone #: _____

Are you in good health? ☐ yes ☐ no If no, please describe _____

Have there been any changes in your medical health in the past 6 months? ☐ yes ☐ no

Are you under the care of a physician? ☐ yes ☐ no Date of last visit _____ Purpose of visit: _____

Have you had any illness, operation, or been hospitalized in the past five years? ☐ yes ☐ no

Have you had any adverse effects from dental treatment? ☐ yes ☐ no Explain: _____

Comments: _____

DENTAL HISTORY

Date of your last dental visit: _____ Purpose of that visit: _____

Date of last routine cleaning appointment: _____ Were x-rays taken? ☐ yes ☐ no Date: ____ /____ /____

Do your gums bleed when you brush? ☐ yes ☐ no Do you grind or clench your teeth?: ☐ yes ☐ no

What is your immediate dental need? _____

What aspect of your smile would you most like to correct? _____

Has anything prevented you from addressing this concern in the past? _____

MEDICATION

ARE YOU NOW TAKING . . .

Over-the-counter medication or vitamins? ☐ yes ☐ no List: _____

Any kind of medication, including prescription, non-prescription or herbal remedies? ☐ yes ☐ no List: _____

Aspirin or Anticoagulant? ☐ yes ☐ no List: _____

Steroids of any type? ☐ yes ☐ no List: _____

Antihistamines? ☐ yes ☐ no List: _____

Are you required to take antibiotics before dental appointments? ☐ yes ☐ no If yes, explain: _____

ALLERGIES

ARE YOU ALLERGIC TO OR HAD A REACTION TO . . .

Local anesthetic (Novocaine)? ☐ yes ☐ no List: _____

Codeine? ☐ yes ☐ no List: _____

Acrylic of Latex Rubber? ☐ yes ☐ no List: _____

Antibiotics? ☐ yes ☐ no List: _____

Any other medications? ☐ yes ☐ no List: _____

Other allergies or Notes? _____

Please list any allergies, including those to medications. _____

Signature _____ Date _____

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HAVE YOU HAD OR DO YOU CURRENTLY HAVE...

Rheumatic Fever?	☐ yes	☐ no	Explain: _____
Heart murmur?	☐ yes	☐ no	Explain: _____
High blood pressure?	☐ yes	☐ no	Explain: _____
Chest pain, angina?	☐ yes	☐ no	Explain: _____
Heart attack (s)?	☐ yes	☐ no	Explain: _____
Mitral valve prolapse?	☐ yes	☐ no	Explain: _____
Swollen ankles, arthritis or joint disease?	☐ yes	☐ no	Explain: _____
Artificial joints or valve replacement?	☐ yes	☐ no	Explain: _____
Thyroid disease?	☐ yes	☐ no	Explain: _____
Diabetes?	☐ yes	☐ no	Explain: _____
Kidney Disease?	☐ yes	☐ no	Explain: _____
Stomach Disease?	☐ yes	☐ no	Explain: _____
Problems of the immune system?	☐ yes	☐ no	Explain: _____
Jaundice or hepatitis?	☐ yes	☐ no	Explain: _____
Bronchitis, chronic cough?	☐ yes	☐ no	Explain: _____
Asthma?	☐ yes	☐ no	Explain: _____
Tuberculosis?	☐ yes	☐ no	Explain: _____
Emphysema?	☐ yes	☐ no	Explain: _____
Difficulty breathing?	☐ yes	☐ no	Explain: _____
Do you smoke or chew tobacco?	☐ yes	☐ no	Explain: _____
Blood disorder such as anemia?	☐ yes	☐ no	Explain: _____
Blood transfusion?	☐ yes	☐ no	Explain: _____
Bleeding tendency or bruise easily?	☐ yes	☐ no	Explain: _____
Immune deficiency?	☐ yes	☐ no	Explain: _____
Neurological problems?	☐ yes	☐ no	Explain: _____
Stroke?	☐ yes	☐ no	Explain: _____
X-ray treatment or chemotherapy?	☐ yes	☐ no	Explain: _____
Significant weight loss or gain?	☐ yes	☐ no	Explain: _____
Cancer or malignancy?	☐ yes	☐ no	Explain: _____
General anesthesia?	☐ yes	☐ no	Explain: _____
Alcohol? (more than 2 drinks per day)	☐ yes	☐ no	Explain: _____
Other conditions?	☐ yes	☐ no	Explain: _____
Is your mouth dry?	☐ yes	☐ no	Explain: _____
Sleep Apnea? Are you being treated for it?	☐ yes	☐ no	Explain: _____

WOMEN

Are you pregnant or planning pregnancy	☐ yes	☐ no	Explain: _____
Are you nursing?	☐ yes	☐ no	Explain: _____
Are you taking birth control pills?	☐ yes	☐ no	Explain: _____

Are you aware that antibiotics (such as penicillin) may alter the effectiveness of birth control pills ☐ *yes* ☐ *no*
If antibiotics are recommended or prescribed please consult your physician/gynecologist for assistance regarding tional methods of birth control.

Patient Questionnaire

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PATIENT INFORMATION SHEET

Today's Date: _____ Account # _____

Whom may we thank for referring you? _____

Patient Name: _____ Date of Birth: _____

How would you like to be addressed? _____ Sex: Male Female *(circle one)*

Home Address: _____
street *city* *state* *zip code*

Occupation: _____ Employer: _____

Social Security # _____ E-mail Address: _____

Home Phone: (____) _____ Business Phone: (____) _____ Ext _____

Circle the phone number you would like us to use when confirming your appointments

Cell Phone: (____) _____ Preferred Fax: (____) _____

FINANCIALLY RESPONSIBLE PARTY

Complete if other than the patient or if the patient is under 18

Name: _____ Social Security # _____

Home Address: _____
street *city* *state* *zip code*

Home Phone: (____) _____ Business Phone: (____) _____ Ext _____

Cell Phone: (____) _____ Preferred Fax: (____) _____

Relationship to Patient: ☐ Parent ☐ Spouse ☐ Guardian ☐ Other

EMERGENCY CONTACT

Person to contact in case of emergency _____ Telephone: _____

Relationship to Patient: ☐ Parent ☐ Spouse ☐ Guardian ☐ Other

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE	SECONDARY DENTAL INSURANCE
Insurance Company with address:	Insurance Company with address:
Employee/Subscriber Name:	Employee/Subscriber Name:
Employee/Subscriber SS # Employee/Subscriber Date of Birth:	Employee/Subscriber SS # Employee/Subscriber Date of Birth:
Group #	Group #
Name of Employer with telephone #	Name of Employer with telephone #
Maximum benefits for year: Year: From ____ To ____	Maximum benefits for year: Year: From ____ To ____

APPOINTMENT POLICY: Our practice is dedicated to your quality treatment and is pleased to reserve the appropriate amount of time for your care. Should a change for your appointment be necessary, a minimum of 24 hour notification is required. This permits another patient to receive dental care in your absence. Without adequate notice, a cancellation fee will be charged.

FAMILY HISTORY

Does anyone in your family have a history of the following?

Diabetes? ☐ yes ☐ no Notes: _____

Heart disease? ☐ yes ☐ no Notes: _____

Bleeding problems? ☐ yes ☐ no Notes: _____

Reaction to anesthesia? ☐ yes ☐ no Notes: _____

Cancer? ☐ yes ☐ no Notes: _____

Lung disease? ☐ yes ☐ no Notes: _____

Is there anything else about your personal or medical condition that the doctor should be aware of before you are treated? ☐ yes ☐ no

If yes please explain _____

As a patient, it is your responsibility to inform the doctor if you are using or taking any non prescription medication, pills, vitamins, supplements or drugs, including "street drugs".

Information provided here: _____

_____

I hereby state that I have answered all of the questions accurately to the best of my knowledge. This form will reveal my complete medical history and assist my doctor in providing the best care possible. I will not hold any doctor or doctors of this practice or any member of the staff responsible for any errors omissions that I have made in the completion of this form.

_____ _____ _____

Signature of the Patient (or guardian) Date Reviewed by

For completion by the Doctor:

_____

_____

_____

_____

_____ _____

Date *Signature*