

MEDICAL AND DENTAL QUESTIONNAIRE

PERSONAL INFORMATION

Full Name: _____

Name you prefer our office to call you: _____

Home Address: Street _____

Town _____ Postal Code _____

Home Telephone #: _____ Business Telephone #: _____

Email: _____ Cell Phone #: _____

Employer: _____

Occupation: _____

Date of Birth: Month _____ Day _____ Year _____

Marital Status: _____

Height: _____ Weight: _____

In case of emergency notify: _____

Relationship (e.g. mother, husband, etc.) _____

Full Address: _____

Telephone: Home _____ Business _____

Person responsible for account: self, insurance, welfare, other _____

Name of insurance company: _____

Referred by: _____

DENTAL HISTORY

Previous Dentist: _____

Address: _____

Telephone #: _____

Date last examined by your dentist: _____

Reason for visit: regular checkup, emergency visit, other _____

- | | Circle | |
|---|---------------|----|
| 1. Are you happy with your smile? | YES | NO |
| 2. Is there anything you would like to change about your smile? | YES | NO |
| Please specify _____ | | |
| 3. Have you ever had local anesthetic (freezing)? | YES | NO |
| 4. Were there any complications: | YES | NO |
| Please specify _____ | | |
| 5. Have you ever had any teeth extracted? | YES | NO |
| 6. Were there any complications involved afterwards? | YES | NO |
| 7. Do your teeth ache? | YES | NO |
| 8. Do your gums bleed when you brush? | YES | NO |
| 9. Do your gums feel tender or swollen? | YES | NO |
| 10. Do you have any loose teeth? | YES | NO |
| 11. Does food catch between your teeth? | YES | NO |
| 12. Are you nervous about going to the dentist? | YES | NO |
| 13. Describe, in your own words, your present dental problem. | | |

MEDICAL HISTORY

Personal Physician: _____

Address: _____

Telephone #: _____

Date last examined by your physician: _____

- | | Circle | |
|---|-------------------|--|
| 1. Is your physician treating you now?
Please specify _____ | YES | NO |
| 2. Have you ever been hospitalized and was surgery performed?
Please specify _____ | YES | NO |
| 3. Have you had a history of congenital heart disease?..... | YES | NO |
| 4. Are your ankles swollen? | YES | NO |
| 5. Have you had infective endocarditis or prosthetic cardiac valves?..... | YES | NO |
| 6. Have you had hepatitis? | YES | NO |
| 7. Have you ever been tested positive for AIDS or HIV?..... | YES | NO |
| 8. Are your activities limited? | YES | NO |
| 9. Do you become breathless easily? | YES | NO |
| 10. Have you had abnormal bleeding? | YES | NO |
| 11. Have you gained or lost excessive weight recently? | YES | NO |
| 12. Have you ever had radiation or X-ray therapy? | YES | NO |
| 13. Have you taken cortisone or steroids? | YES | NO |
| 14. Have you any allergies? (e.g. rubber gloves, balloons, latex) | YES | NO |
| 15. Have you had an allergic reaction to any drugs or medicines? (e.g. penicillin) | YES | NO |
| Please specify _____ | | |
| 16. Are you taking any prescription or non-prescription drugs or medicines? | YES | NO |
| Please specify _____ | | |
| 17. Do you have or have you had? Circle | | |
| Heart Trouble | Epilepsy | Blood Disorders |
| High Blood Pressure | Thyroid Trouble | Diabetes |
| Kidney Trouble | Tuberculosis | Anemia |
| Liver Trouble (e.g. jaundice) | Asthma | Venereal Diseases
(syphilis, gonorrhea) |
| Stroke | Nervous Disorders | Convulsions |
| Cancer | | |
| Any others, please specify _____ | | |
| 18. Have you ever fainted? | YES | NO |
| 19. Are you on a special diet? | YES | NO |
| 20. Are you currently in good health? | YES | NO |
| 21. Do you smoke? | YES | NO |
| Amount per day _____ | | |
| 22. Is there anything else you think you should tell me? | YES | NO |
| 23. Blood Pressure _____ / _____ | | 24. Pulse _____ |
| FOR WOMEN ONLY | | |
| 25. Are you pregnant? If so, what month? | YES | NO |
| | ASA | _____ |

OFFICE POLICY

Your appointment time will be reserved especially for you. If you are unable to keep the appointment we will require 48 hours notice, otherwise, it will be necessary to charge for time lost.

Office policy is that services rendered in this office are the financial responsibility of the patient. We cannot accept direct payment from your insurance company, although we will be pleased to fill out the necessary forms so that you may be properly reimbursed. Please discuss arrangements for payment with the doctor or receptionist.

PATIENT CONSENT and APPROVAL

I, the undersigned, certify that all of the above medical and dental information is true to my knowledge and I have not omitted any pertinent information and consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetic and nitrous oxide as indicated. I will assume responsibility for fees associated with these procedures.

Signature _____ Date _____

(Guardians may consent and sign for children)