



Dental and Medical Information Questionnaire

Name _____ Date of Birth _____

SSN _____ School _____

E-mail address _____

Phone Numbers

Home _____ Work _____ Cell _____

General Information

1. Home Address _____

2. Employer Name and Address _____

3. Insurance Company Name and Address _____

4. Referring Dentist/Physician Name and Address _____

Dental Information

1. Reason for visit _____

2. Date of last treatment _____

3. Date of last teeth cleaning _____

4. How often do you brush? _____

5. How often do you floss? _____

6. Do you supplement your diet with fluoride? YES NO

7. Are you having pain at this time? YES NO

Have you had any of the following?

- | | | |
|---|-----|----|
| 1. Orthodontic treatment (braces) | YES | NO |
| 2. Oral surgery | YES | NO |
| 3. Gum treatment | YES | NO |
| 4. Your teeth ground or bite adjusted | YES | NO |
| 5. Worn a bite plane or other appliance | YES | NO |

Have you noticed?

- | | | |
|---|-----|----|
| 1. Any loosening of your teeth | YES | NO |
| 2. Food becomes caught between teeth | YES | NO |
| 3. Your gums bleed when you brush | YES | NO |
| 4. Any sores or lumps near or in your mouth | YES | NO |

Do you have any of these jaw problems?

- | | | |
|---------------------------------------|-----|----|
| 1. Clicking of the jaw | YES | NO |
| 2. Pain (joint, ear, or side of face) | YES | NO |
| 3. Difficulty in opening and closing | YES | NO |
| 4. Difficulty in chewing | YES | NO |
| 5. Any head, neck, or jaw injuries | YES | NO |

Do you?

- | | | |
|---|-----|----|
| 1. Clench or grind your teeth (awake or sleeping) | YES | NO |
| 2. Bite your lips or cheeks frequently | YES | NO |
| 3. Thumb-suck or nail-bite | YES | NO |
| 4. Open things up with your teeth | YES | NO |

General

- | | | |
|--|-----|----|
| 1. Have you ever had an upsetting experience in a dental office? | YES | NO |
| 2. Is it important to you to keep your teeth? | YES | NO |
| 3. Are you dissatisfied with the appearance of your teeth? | YES | NO |
| 4. Does dental treatment bother you? | YES | NO |

If yes to any dental questions please explain

Medical Information

- | | | |
|--|-----|----|
| 1. Has there been any change in your health within the past year? | YES | NO |
| 2. Are you under the care of a physician? | YES | NO |
| 3. Have you been hospitalized for an operation or serious illness? | YES | NO |
| 4. Have you had your blood pressure checked in the last 6 months? | YES | NO |
| Was it normal? | YES | NO |
| 5. Last physical exam date _____ | | |
| 6. Name, address and phone of your physician _____ | | |
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Do you or have you had any of the following?

- | | | |
|---|-----|----|
| 1. Rheumatic fever, Scarlet fever, or Rheumatic heart disease | YES | NO |
| 2. Heart defect or heart murmur | YES | NO |
| 3. Heart trouble, heart attack, or angina | YES | NO |
| 4. Pain in your chest upon exertion | YES | NO |
| 5. Are you ever short of breath after mild exercise | YES | NO |
| 6. Ankles swell | YES | NO |
| 7. Get short of breath when you lie down | YES | NO |
| 8. Require extra pillows when you sleep | YES | NO |
| 9. Pacemaker | YES | NO |
| 10. Heart surgery | YES | NO |
| 11. High blood sugar Diabetes Type I Type II | YES | NO |
| 12. Stroke | YES | NO |
| 13. Hepatitis? A, B, C, D, E, F, G, H | YES | NO |
| 14. Sinus trouble | YES | NO |
| 15. Lung or breathing problems | YES | NO |
| 16. Asthma or hay fever | YES | NO |
| 17. Hives or skin rash | YES | NO |
| 18. Fainting spells or seizures | YES | NO |
| 19. HIV? ARC? AIDS? | YES | NO |
| 20. Allergies | YES | NO |
| 21. Liver disease or jaundice | YES | NO |
| 22. Thyroid problems | YES | NO |
| 23. Arthritis, rheumatism | YES | NO |
| 24. Joint replacement or implant | YES | NO |
| 25. Stomach ulcers, acid reflux or eating disorder | YES | NO |

26. Kidney trouble, kidney transplant or dialysis	YES	NO
27. Tuberculosis	YES	NO
28. Low blood pressure	YES	NO
29. Use tobacco (smoke, chew)	YES	NO
30. Chemical dependency (drugs, alcohol)	YES	NO
31. Venereal disease	YES	NO
32. Any type of transplant	YES	NO
33. Abnormal bleeding associated with previous tooth extractions, surgery or injuries	YES	NO
34. Bruise easily	YES	NO
35. Ever required a blood transfusion, If yes when? _____	YES	NO
36. Any blood disorders (anemia or leukemia)	YES	NO
37. Any eye problems (glaucoma)	YES	NO
38. Surgery or x-ray treatment for a tumor, growth, or other condition of your mouth or lips	YES	NO

Are you taking any of the following?

1. Antibiotics or sulfa drugs	YES	NO
2. Anticoagulants (blood thinners)	YES	NO
3. Medicine for high blood pressure	YES	NO
4. Cortisone (steroids)	YES	NO
5. Tranquilizers	YES	NO
6. Dilantin	YES	NO
7. Antihistamines	YES	NO
8. Aspirin	YES	NO
9. Insulin, Tolbutamide (Orinase) to control blood sugar	YES	NO
10. Digitalis or drugs for heart trouble	YES	NO
11. Nitroglycerin	YES	NO
12. Oral contraceptives	YES	NO
13. Boniva, Fosamax, Actonel, Reclast, or other medications for the treatment of osteoporosis	YES	NO
14. HRT (hormone replacement therapy)	YES	NO
15. ED meds such as Viagra, Levitra, Cialis (tadalafil)	YES	NO
16. Antidepressants or anti-anxiety medications	YES	NO

List all meds you take on a regular basis or provide a copy of your meds to the receptionist to be scanned into your chart

Are you allergic to or have you received reactions to

- | | | |
|---|-----|----|
| 1. Local anesthetics like Novocain | YES | NO |
| 2. Penicillin or other antibiotics | YES | NO |
| 3. Sulfa drugs | YES | NO |
| 4. Barbiturates, sedatives, or sleeping pills | YES | NO |
| 5. Aspirin | YES | NO |
| 6. Iodine | YES | NO |
| 7. Other _____ | YES | NO |

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|--|-----|----|
| Have you had any trouble with a previous dental treatment? | YES | NO |
| Does anyone in your family have any disability, birth defects, or growth related problems? | YES | NO |
| Are you wearing contact lenses? | YES | NO |

Women

- | | | |
|--|-----|----|
| 1. are you pregnant or think you might be pregnant? | YES | NO |
| 2. Have you had a miscarriage or a still birth? | YES | NO |
| 3. Have you had a baby with birth weight more than 10 lbs? | YES | NO |
| 4. Are you nursing presently? | YES | NO |
| 5. Do you have any disease, condition, or problem not listed above that you think I should know about? | YES | NO |

If yes to any of the above, please explain

Late Charges

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except dental emergencies where there is prepayment for additional services. In case of default on payment, I agree to pay collections cost and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

Authorization and Release

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand my dental insurance may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature (Parent or Guardian signature if patient is under 18)

Date