WELCOME
TO OUR PRACTICE!

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

PATIENT INFORMATION

Date _____ Soc. Sec. # _____ Birthdate _____

Name _____
Last Name First Name Initial

Address _____ Home Phone _____

City _____ State _____ Zip _____

Sex: ☐ M ☐ F ☐ Minor ☐ Single ☐ Married ☐ Long Term Partner ☐ Divorced ☐ Widowed ☐ Separated

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Who should we thank for referring you? _____

In case of emergency, who should we contact? _____ Phone _____

PRIMARY DENTAL INSURANCE

Person Responsible for Account _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Responsible Party Employed By _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

ADDITIONAL INSURANCE

Insured Name _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Insured Employed By _____ Business Phone _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

Please complete reverse side

HEALTH QUESTIONAIRE

Patient Name_____

Sex_____ Age_____ Height_____ Weight_____

Date_____ Occupation_____

Marital Status_____

Directions

Please circle the appropriate answer to the questions and fill in the blanks where indicated. Answer all questions and blanks completely.

Answers to the following questions are for our records and will be considered confidential.

1. Are you in good health..... Yes No
   A. Has there been any change in your general health ..... Yes No
2. My last physical examination was on _____
3. Are you now under the care of a physician ..... Yes No
   A. If so, what is the condition being treated _____
4. The name and address of my physician is: _____ _____
5. Have you had a serious illness or operation ..... Yes No
   A. If so, what was the illness or operation:_____ _____ _____
6. Have you been hospitalized or had serious illness within the last five (5) years ..... Yes No
   A. Do you have a persistent cough or cough up blood ..... Yes No
   B. Low blood pressure ..... Yes No
   C. Venereal Disease ..... Yes No
   D. AIDS or HIV+..... Yes No
   E. Other_____ _____
7. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma ..... Yes No
   A. Do you bruise easily ..... Yes No
   B. Have you ever required a blood transfusion ..... Yes No
   If so, explain the circumstances_____ _____
8. Do you have any blood disorder such as anemia..... Yes No
9. Have you had surgery or x-ray treatment for a tumor, growth or other condition of your mouth or lips..... Yes No
10. Are you taking any drug or medication..... Yes No
    If so, what_____ _____
11. Are you taking any of the following:
    A. Antibiotics or sulfa drugs..... Yes No
    B. Anticoagulants (blood thinners)..... Yes No
    C. Medicine for high blood pressure..... Yes No
    D. Cortisone (steroids)..... Yes No
    E. Tranquilizers..... Yes No
    F. Aspirin..... Yes No
    G. Insulin, Tolbutamide (Orinase) or similar drug..... Yes No
    H. Digitalis or drugs for heart trouble..... Yes No
    I. Nitroglycerin..... Yes No
    J. Fen-Phen (now, or in the past)..... Yes No
    K. Oral Contraceptives..... Yes No
    If so, what are you using_____ _____
    L. Other_____ _____
12. Do you have a heart murmur/mitral valve prolapse..... Yes No
13. Do you have any implants and/or Prosthesis (i.e. knee joints, elbow pins, etc.)..... Yes No
    If so, explain_____
14. Do you drink alcoholic beverages..... Yes No
15. Do you smoke..... Yes No
    If so, how much_____
16. Do you have or have you had any of the following diseases or problems:
    A. Rheumatic fever or rheumatic heart disease..... Yes No
    B. Congenital heart lesions..... Yes No
    C. Cardiovascular disease (heart trouble, heart attack, coronary occlusion, high blood pressure, arteriosclerosis, stroke)... Yes No
       1) Do you have pain in the chest upon exertion..... Yes No
       2) Are you ever short of breath after mild exercise..... Yes No
       3) Do you get short of breath when you lie down or do you require extra pillows when you sleep..... Yes No
    D. Allergy..... Yes No
    E. Asthma or hay fever..... Yes No
    F. Hives or skin rash..... Yes No
    G. Fainting spells or seizures..... Yes No
    H. Diabetes..... Yes No
       1) Do you have to urinate (pass water) more than six (6) times a day..... Yes No
       2) Are you thirsty much of the time..... Yes No
       3) Does your mouth frequently become dry..... Yes No
    I. Hepatitis, jaundice, or liver disease..... Yes No
    J. Arthritis..... Yes No
    K. Inflammatory rheumatism (painful, swollen joints).. Yes No
    L. Stomach ulcers..... Yes No
    M. Kidney trouble..... Yes No
    N. Tuberculoses..... Yes No
17. Are you allergic or have you reacted adversely to:
    A. Local anesthetic..... Yes No
    B. Penicillin or other antibiotics..... Yes No
    C. Barbiturates, sedatives, or sleeping pills..... Yes No
    D. Sulfa Drugs..... Yes No
    E. Aspirin..... Yes No
    F. Iodine..... Yes No
    G. Latex..... Yes No
    H. Other:_____
18. Have you had any serious trouble associated with previous dental treatment..... Yes No
    If so, explain_____ _____
19. Are you pregnant or could you be..... Yes No
    If so, when are you due?_____

I certify to the best of my knowledge that the above information is correct and that if there are any changes in the above, I agree to notify my dentist before my next visit.

Patient/Guardian_____ Date_____

Doctor _____ Date_____

Updates:

Patient/Guardian_____ Doctor's Initials_____ Date_____

Patient/Guardian_____ Doctor's Initials_____ Date_____

Patient/Guardian_____ Doctor's Initials_____ Date_____