

PATIENT QUESTIONNAIRE

Name _____ Date _____
 Address _____ Home Phone _____
 City _____ State _____ Zip Code _____ Work Phone _____
 Birthdate _____ Age _____ Sex _____ Spouse's Name _____
 Are you: Married Single Divorced Widowed Student
 Social Security Number _____/_____/_____ Spouse's Social Security Number _____/_____/_____

Person responsible for payment of this account. (If same as above, please omit.)

Name _____ Home Phone _____
 Address _____ Work Phone _____
 City _____ State _____ Zip _____ Relationship to Patient _____
 Employer _____ Social Security No. _____/_____/_____

Employer _____ Position _____
 Address of Employer _____ Phone _____
Spouse's Employer _____ Position _____
 Address of Employer _____ Phone _____

Do you have dental insurance? yes no

PRIMARY INSURANCE

SECONDARY INSURANCE

Subscriber Name	_____	_____
Insurance Company	_____	_____
Social Security Number	_____	_____
Birthdate	_____	_____
Carrier/Group Number	_____	_____
Relationship to Patient	_____	_____

Credit Card Name	MC or VISA	Account Number	Expiration Date
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DENTAL HISTORY

How long since you last visited a dentist? _____ Reason? _____
 Have you ever had any teeth extracted? _____ Were there complications? _____
 How often do you brush your teeth? _____
 Do you use dental floss? _____ How often? _____
 Do you have a problem with bad breath? _____
 Do you have any painful areas, sensitive teeth or bleeding gums in your mouth at this time? _____
 Where? _____
 What is the reason for your dental visit? _____
 What would you like to change about your smile or teeth? _____

Are you interested in	Yes	No
Whiter or brighter looking teeth	()	()
Orthodontic treatment to straighten teeth or correct bite	()	()
Replace missing teeth	()	()
Correct chipped or broken teeth	()	()
Replace old unsightly fillings	()	()

MEDICAL HISTORY

Yes No

Have you been under a physician's care or hospitalized within the last 2 years? () ()

Please state reason _____

Have you taken any medication or aspirin in the last 48 hours? () ()

Please list _____

Are you allergic to any medication? () ()

Please list _____

Have you ever had any type of reaction to penicillin? () ()

Have you ever had a reaction to a local/dental anesthetic? () ()

Do you bleed easily, or of long duration when cut? () ()

Have you had a blood transfusion within the last two years? () ()

Have you had any heart problems, heart valve damage, congenital heart disease, artificial heart valve, or pace maker? () ()

Please list _____

Have you had any artificial joint replacement, pins, or plates put in your bones? () ()

Please list _____

Circle any of the following which you have had:

- | | | |
|----------------------------|----------------------|--------------------|
| Anemia | Hepatitis | Low Blood Pressure |
| Asthma | HIV (AIDS) | Pneumonia |
| Cancer/Tumors | High Blood Pressure | Rheumatic Fever |
| Diabetes | Jaundice | Sinus Trouble |
| Epilepsy/Seizures/Fainting | Liver/Kidney Disease | Stroke |
| Heart Surgery/Problems | | |

Have you had any other serious illnesses? () ()

Please list _____

Have you been exposed to HIV (AIDS) through surgery, transfusion or intravenous drug use, or prior sexual history? () ()

(Woman) are you pregnant now? () ()

Who is your physician? _____ Phone Number _____

Who may we thank for referring you to our office? _____

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

I accept full responsibility for the above information and understand I am responsible for payment of services rendered.

Signature _____ Date _____