

Name: _____ Address: _____
First M.I. Last Number and Street
City: _____ State: _____ Zip: _____ Marital Status: _____

Social Security No.: _____ Spouse's Name: _____
Spouse's Social Security No.: _____

Telephone No.: _____ Work: _____ Date of Birth: _____
Cell Phone: _____

Employer: _____ Address: _____
Street, City, Zip

Present Position: _____ How Long Held: _____

Spouse Employed By: _____ Address: _____
Street, City, Zip

Person Responsible for this Account: _____ Relationship: _____

Referred to Our Office By: _____

Closest Relative Not Living With You: _____ Phone: _____

Are you covered by any Dental Insurance? _____ Yes _____ No
Name of Primary Insurance: _____ ID No. _____ Group No. _____
Name of Secondary Insurance: _____ ID No. _____ Group No. _____

For the following questions, check yes or no, whichever applies. If you do not understand the question, discuss with the doctor. Your answers are to enable us to provide the best care and will be considered strictly confidential. They will not be released without your permission.

1. Are you under the care of a physician at this time?.....Yes _____ No _____
If so, condition(s) being treated _____
Personal Physician – Name _____
Address _____
Phone _____
2. Have you ever had any serious illness or operation?.....Yes _____ No _____
If yes, what was the problem? _____
Approximate date of last physical examination _____
3. Do you now have or have you ever had any of the following diseases or conditions?
 - a. Mitral Valve Prolapse?.....Yes _____ No _____
 - b. Congenital heart lesions or heart murmur?.....Yes _____ No _____
 - c. Rheumatic fever or rheumatic heart disease?.....Yes _____ No _____
 - d. Prosthetic joints, pins, plates?.....Yes _____ No _____
 - e. Glaucoma?.....Yes _____ No _____
 - f. Cardiovascular Disease (heart trouble, heart attack, coronary insufficiency stroke)?.....Yes _____ No _____
 - g. Do you have High Blood Pressure?.....Yes _____ No _____
 - h. Do you have Low Blood Pressure?.....Yes _____ No _____

PLEASE COMPLETE THE OTHER SIDE

- i. Do you have pain the in the chest upon exertion?..... Yes ___ No ___
 - j. Are you short of breath after mild exercise?..... Yes ___ No ___
 - k. Do you get short of breath if you lie down?..... Yes ___ No ___
 - l. Do you have a cardiac pacemaker?..... Yes ___ No ___
 - m. Do you have fainting spells or seizures?..... Yes ___ No ___
 - o. Do you have sinus trouble?..... Yes ___ No ___
 - p. Do you have diabetes?..... Yes ___ No ___
 - q. Do you have arthritis?..... Yes ___ No ___
 - r. Do you have stomach ulcers?..... Yes ___ No ___
4. Are you allergic to or have you reacted adversely to any drugs or medications?. Yes ___ No ___
If so, please explain _____
5. Have you had surgery or X-ray treatment for a tumor, or growth, or other
Conditions of your head or neck?..... Yes ___ No ___
6. Do you have any reason to believe that you have been exposed to:
- a. The AIDS (HIV) virus?..... Yes ___ No ___
 - b. Hepatitis B virus?..... Yes ___ No ___
7. Are you currently or have you in the past used any Bisphosphonates such as:
Fosamax, Actonel, or Boniva..... Yes ___ No ___
Please list medication _____
8. Are you taking ANY medications?..... Yes ___ No ___
Please list all medications _____
9. Have you had abnormal bleeding associated with previous extractions,
surgery, or trauma?..... Yes ___ No ___
If so, please explain _____ Yes ___ No ___
10. Have you had any serious trouble associated with any previous dental treatment? Yes ___ No ___
If so, please explain _____
11. Any other problems listed that we should be aware of?..... Yes ___ No ___
If so, please explain _____
12. Are you wearing contact lenses?..... Yes ___ No ___

WOMEN PLEASE ANSWER THE FOLLOWING:

- a. Are you pregnant?..... Yes ___ No ___
- b. Are you nursing?..... Yes ___ No ___
- c. Are you currently taking birth control pills?..... Yes ___ No ___

WHAT IS YOUR CHIEF DENTAL COMPLAINT OR REASON FOR SEEKING TREATMENT?

I certify that this questionnaire was completed to the best of my ability. I further realize that my dental treatment will be based on the information given. I will advise the doctor of any changes in the information contained herein as soon as possible.

Signature of Patient or Authorized Person _____
Date

Update: _____ Initials: _____ Update: _____ Initials: _____ Update: _____ Initials: _____