DENTAL HEALTH QUESTIONNAIRE

We request payment at the time of service.

If there is a reason why this may be difficult for you at this time, please mention it in advance to the receptionist. Thank you.

These questions are important for your welfare. If your immune system is depressed, then the necessary antibiotic therapy must be more stringent than if your immune system is healthy. Please help us to provide you with the best dental care humanly possible. If you have any questions, please ask the dentist.

PATIENT'S NAME FIRST ____ MIDDLE ____ LAST ____ CHILD ____ SINGLE ____ MARRIED ____ WIDOWED ____ SEPARATED ____

DATE OF BIRTH ____ SEX ____ PATIENT'S SS# ____ PATIENT'S HOME PHONE NUMBER ( ) ____

PATIENT'S ADDRESS ____ CITY ____ STATE ____ ZIP ____

RESPONSIBLE PARTY ____ ADDRESS ____ CITY ____ STATE ____ ZIP ____

RESPONSIBLE PARTY'S EMPLOYMENT ____ POSITION ____ HOW LONG? ____

RESPONSIBLE PARTY'S HOME PHONE ( ) ____ RESPONSIBLE PARTY'S WORK PHONE ( ) ____ RESPONSIBLE PARTY'S CELL PHONE ( ) ____

RESPONSIBLE PARTY'S EMAIL ____ RESPONSIBLE PARTY'S SS# ____

SPOUSE ____ SPOUSE'S EMPLOYMENT ____ SPOUSE'S WORK PHONE ( ) ____

REFERRED BY ____ ADDRESS ____

NAME OF YOUR DENTAL INSURANCE CO. ____ GROUP & ID NUMBER ____ SPOUSE'S INSURANCE ____ SPOUSE'S GROUP & ID NUMBER ____

EMPLOYEE'S DATE OF BIRTH ____ EMPLOYEE'S SS# ____ NAME OF EMPLOYER INSURANCE IS CARRIED WITH ____

RELATIVE NOT LIVING WITH YOU ____ HOW RELATED ____ ADDRESS ____ PHONE ( ) ____

It is important that we know about your dental and medical history. Many things have a direct bearing on your dental health. We will review the questionnaire and discuss it with you in detail. Information you give us is strictly confidential and will not be released to anyone without your written permission.

1. The name and address of my physician is ____________________
2. My last physical examination was on ____________________
3. Has there been any change in your general health within the past year .... YES NO
4. Are you now under the care of a physician .... YES NO
   a. if so, what is the condition being treated ____________________
5. Have you been hospitalized or had a serious illness within the past five (5) years .... YES NO
   a. if so, what was the problem ____________________
6. Please circle any illnesses you have ever had:

rheumatic fever	sinus trouble	shortness of breath
heart murmur	asthma or hay fever	allergy
heart attack	hives or a skin rash	tuberculosis
coronary insufficiency	fainting spells or seizures	kidney trouble
high blood pressure	diabetes	persistent cough or cough up blood
low blood pressure	hepatitis, jaundice or liver disease	artificial joints
swollen ankles	stomach ulcers	

7. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma .... YES NO
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. (Women) Are you pregnant .... YES NO

11. Are you taking any of the following:
   a. Antibiotics or sulfa drug .... 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. Antihistamines .... YES NO
   g. Aspirin .... YES NO
   h. Insulin, tolbutamide (Orinase) or similar drug .... YES NO
   i. Digitalis or drugs for heart trouble .... YES NO
   j. Nitroglycerin .... YES NO

   k. Other ______________________________

12. Are you allergic or have you reacted adversely to:
   a. Local anesthetics .... YES NO
   b. Penicillin or other antibiotics .... YES NO
   c. Sulfa drugs .... YES NO
   d. Barbiturates, sedatives or sleeping pills .... YES NO
   e. Aspirin .... YES NO
   f. Iodine .... YES NO
   g. Codeine or other narcotics .... YES NO

   h. Other ______________________________

13. Have you ever had serious trouble associated with any previous dental treatment .... YES NO

   If so explain ______________________________

   ____

14. Do you have any disease, condition, or problem not listed above .... YES NO

   If so explain ______________________________

   ____

YOUR DENTAL HISTORY

Are you have any discomfort at this time? ______________________________

How long since you have been to the dentist? ____________________ Why? ____________________

What was done then? ______________________________

Are your teeth sensitive to hot, cold, or sweets? ______________________________

How often do you brush? ______________________________

How often do you floss? ______________________________

Do your gums bleed? ______________________________

Have you ever had gum treatments? ______________________________

Do you grind, grit, or clench your teeth? ______________________________

Do you have any popping, clicking, or snapping noise when you chew? ______________________________

Are you aware of any swelling, lumps, or sores in your mouth? ______________________________

What is the name and address of your previous dentist? ______________________________

Why did you leave your previous dentist? ______________________________

____
Signature of Patient Date

____
Signature of Dentist

DENTAL HEALTH QUESTIONNAIRE

Name ____ Date__________________

The following questions are very important to you and the dentist and his staff. These questions are intended for therapeutic reasons only, and the answers are **confidential**, however, they may be shared with subsequent treating dentists or physicians.

HIV (AIDS)

1. a. Have you ever tested positive for HIV? .... YES NO

b. Do you have any reason to believe that you are at risk of being HIV positive? .... YES NO

c. Have you ever “shot up” drugs? .... YES NO

d. Have you ever had sex with a man or woman who has “shot up” drugs? .... YES NO

2. Have you ever had hepatitis .... YES NO

a. Type A .... YES NO

b. Type B .... YES NO

c. Type C .... YES NO

3. Have you ever tested positive for tuberculosis .... YES NO

a. Received treatment .... YES NO

b. Results____

____

These questions are important for your welfare. If your immune system is depressed, then the necessary antibiotic therapy must be more stringent than if your immune system is healthy. Please help us provide you with the best dental care humanly possible. If you have any questions, please ask the dentist.

Thank You

Signed __________________________________ Dentist ____________________________________

Date __________________________________

MEDICAL HISTORY UPDATES

I have read my MEDICAL HISTORY and confirm that it adequately states past and present conditions.

Date	Changes	Patient's Signature	Reviewed By