Medical & Dental History Questionnaire

Title: ☐ Mr.☐ Mrs. ☐Ms.☐ Ms.☐ Miss.☐ Dr.

Name: (first) (last) (initial)
____

Nick Name: ____

Date of Birth(D/M/Y):____

Home Address: ____

Suite: ________________ City: ___________________________ Postal Code ____________________

☐Home Phone: ______________________________________

☐Cellular Phone: _____________________________________

☐Business Phone: ____________________________________

☐Email: ____

How did you hear about our office? ____

Do you have dental insurance? ☐Yes ☐No

Primary Ins. Name of insurance company/Policy#/Cert.#

____

____

Secondary Ins. Policy#/Cert.#:
____

MEDICAL HISTORY: The following information is required to enable us to provide you with the best possible dental care. All information is strictly private and is protected. Please fill in the entire form.

1.Are you being treated for any medical condition at the present or have been treated within the past year? If so, what was the treatment rendered. Please write a brief description:
____

____

2.When was your last medical checkup? ____

3.Has there been any change in your general health in the past year? If yes, please explain. ☐Yes ☐No ☐
____

4.Are you taking any medications, non-prescription drugs, natural supplements of any kind? If yes please list with doses or provide list.
____

5.Do you have any allergies? If yes please list below ☐Yes ☐No
a) To medications: ____

b) To latex / rubber products/ metals: ____

c) Other (Ie. hay fever, foods, dyes): ____

6.Have you ever had a peculiar or adverse reaction to any medications or injections? ☐Yes ☐No
If yes, please explain: ____

7.Do you have or ever had asthma? ☐Yes ☐No

8.Do you have or ever had any heart or blood pressure problems? ☐Yes ☐No

9.Do you have or ever had a replacement or repair of a heart valve, infection of the heart (infective endocarditis), a heart condition from birth (congenital heart disease) or a heart transplant? ☐Yes ☐No

10. Do you have any prosthetic or artificial joint(s)? (Ie. Hip or knee) ☐Yes ☐No

11.Do you have any condition or therapies that could affect your immune system? (i.e. chemotherapy, radiotherapy, leukemia, AIDS/HIV infection) ☐Yes ☐No

12. Have you ever had hepatitis, jaundice (other than birth) or liver disease? ☐Yes ☐No

13. Do you have a bleeding problem or bleeding disorder? __ ☐Yes ☐No

14. Have you ever been hospitalized for any illness? Or had any surgeries? If Yes please explain ☐Yes ☐No

15. Do you have or ever had any of the following? Please check.

☐Chest pain, angina ☐rheumatic fever ☐lung disease ☐stomach ulcers ☐Drug/alcohol dependency

☐Heart attack ☐tuberculosis ☐arthritis ☐osteoporosis medications

☐stroke ☐cancer ☐seizure(epilepsy)

☐shortness of breath ☐heart murmur ☐steroid therapy ☐kidney disease ☐pace maker

☐diabetes ☐thyroid disease ☐organ transplant ☐malignant hypothermia ☐mental health disorder

16.Are there any conditions or diseases not listed above that you have or have had? If so, what?

____

17. Are there any diseases that run in your family (e.g. diabetes, cancer, heart disease)
☐Yes ☐No

18.Do you smoke /use tobacco/marijuana products? ☐Yes ☐No If yes, how much per day? _____

How many years? ____

FOR WOMEN ONLY:

1.Are you pregnant? ☐Yes ☐No

2. Are you breast feeding? ☐Yes ☐No

3. Are you on birth control pills? ☐Yes ☐No

DENTAL HISTORY

1.When was your last dental visit? ____

2. When was your last cleaning? ____

3.How would you describe your dental health at present? _ ☐Good ☐Fair ☐Poor

5.What are your present dental concerns, if any?

☐Bleeding Gums ☐Crooked teeth ☐Cosmetic ☐Loose Teeth ☐Bad Breath ☐Food trapping ☐Sensitive Teeth

☐Toothache ☐Loose Dentures ☐Missing teeth/spaces ☐want whiter teeth Other:

6.Have you ever had complications after extractions? ☐Yes ☐No

7. Are you anxious during dental visits? ☐Yes ☐No

PATIENT CERTIFICATION AND CONSENT

I, the undersigned, certify that all the above medical and dental information is true to the best of my knowledge and that I have not omitted any pertinent information. I agree to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetics or other prescribed drugs as indicated. I consent to the electronic sharing of information with my insurance company for the purposes of processing insurance claims and the determination of benefits. Unless other arrangements are made payment is due at each office visit. Unpaid accounts may be subject to interest. My dental insurance plan is a contract between myself and my insurance company, not between my insurance company and the dentist. I authorize the dentist to treat me and I assume full responsibility of the fees. I am aware that 2 business days notice is required to change or cancel an appointment without charge.

Signature, (parent or guardian) ____

Date ____