

HEALTH/ INSURANCE QUESTIONNAIRE

The information request below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided will be kept in strict confidence unless allowed or required by law. Your written permission will be required to release any information.

DATE _____ LAST NAME _____ FIRST NAME _____
Date of birth: Mo. ____ Day ____ Yr. ____ Sex: F/ M Primary#: _____ Cell/Work: _____
Address: _____ City: _____ Postal Code: _____
Email Address: _____ Confirm your appointments via email: Yes/ No
Emergency contact (name) _____ Number: _____ Relationship: _____
Dental insurance? Yes/ No Insurance Company _____ Policy# _____
Cardholders name: _____ Date of birth: _____
How did you find us _____ Last dental exam _____

Have you ever been referred for general anesthesia, intravenous or nitrous oxide sedation? Yes/No

Are you nervous or anxious during dental treatment? Yes/ No

Please check off if you have any of the following concerns:

Toothache Extraction required Sore gums Implants Dentures Wisdom teeth
 Crown/bridge work Regular check up Dental cleaning broken filling/tooth

Medical History

Health Card #: _____ Physician _____

1) Are you presently being treated by a physician? Yes/No 2) Last medical exam _____

3) Are you taking any prescribed medications, non-prescription drugs or herbal supplements of any kind? Yes/ No

If yes, name, dose and frequency

4) Do you smoke or chew tobacco? Yes/No 5) Do you drink alcohol? Yes/No 6) Recreational Drugs _____

7) If female, are you pregnant? Yes/ No 8) Do you snore or have been told you stop breathing while asleep? Yes/No

9) Have you ever been hospitalized? Yes/No If yes why? _____

10) Do you have a prosthetic heart valve? Yes/No 11) Do you have a pacemaker? Yes/No

12) Any previous surgery? Yes/ No If yes what? _____

13) Have you ever had radiation treatment to your head or neck? Yes/No

14) Is there any condition that we should be aware of that would assist us with your treatment? _____

15) Have you ever had or been treated for the following?

<input type="checkbox"/> Liver disorder	<input type="checkbox"/> Kidney disorder	<input type="checkbox"/> Heart attack	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Acid Reflux
<input type="checkbox"/> Endocarditis	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> Breathing Problems	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Anemia	<input type="checkbox"/> Stroke	<input type="checkbox"/> Angina	<input type="checkbox"/> Cancer	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> Hepatitis A,B,C	<input type="checkbox"/> Artificial joints	<input type="checkbox"/> Bleeding problems	<input type="checkbox"/> HIV	<input type="checkbox"/> STD

16) Are you allergic to any of the following?

Penicillin Latex Steroids Barbiturates Local Anesthetics Tetracycline Aspirin Erythromycin Codeine
 Valium/Benzodiazepines Metals Foods Other _____

The information I have given above is true and to the best of my knowledge. _____

Date M ____ D ____ Y ____

Patient or Guardian Signature