**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_____ Certificate /Subscriber ID#_____

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?

| | | | | |
|---|---|---|---|---|
| ___ Liver disorder | ___Kidney disorder | ___ Heart attack | ___ Diabetes | ___Acid Reflux |
| ___ Endocarditis | ___ High blood pressure | ___ Seizure Disorder | ___ Breathing Problems | ___Osteoporosis |
| ___ Anemia | ___ Stroke | ___ Angina | ___ Cancer | ___Thyroid problems |
| ___ Hepatitis A,B,C | ___ Artificial joints | ___Bleeding problems | ___HIV | ___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**