

## 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 # \_\_\_\_\_ /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?

<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**