DENTAL PATIENT INFORMATION & HEALTH HISTORY QUESTIONNAIRE

We are pleased to welcome you to our practice. Please complete this form entirely. The following information is necessary to enable us to provide you with your best dental care. All information disclosed is confidential.

Name *(Last, First, M.I.):* _____ ☐ M ☐ F **Date:** _____

DOB: _____ **Marital Status:** ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Address: _____ **Email:** _____

City: _____ **State:** _____ **Zip:** _____

Home: _____ ☐ **Work:** _____ ☐ **Cell:** _____ ☐

Please indicate (X) which number is your preferred contact Are you ok having appointments confirmed via text message? ☐ Yes ☐ No

Employer/School: _____ **Occupation:** _____

Employer/School Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Spouse Name: _____ **Spouse Work#** _____ **Spouse Cell#** _____

If patient is a minor, who is legally responsible? _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Emergency Contact: _____ **Relationship:** _____

Home: _____ **Work:** _____ **Cell:** _____

Whom may we thank for referring you? _____

DENTAL INSURANCE

Primary Insurance

Insured Name *(Last, First, M.I.):* _____ **DOB:** _____ **SS#:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Relationship to patient:** _____

Insured's Employer: _____ **Occupation:** _____

Business Address: _____ **Business Phone:** _____

Insurance Co.: _____ **Member ID#:** _____

Phone: _____ **Group #:** _____

Secondary Insurance

Insured Name *(Last, First, M.I.):* _____ **DOB:** _____ **SS#:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Relationship to patient:** _____

Insured's Employer: _____ **Occupation:** _____

Business Address: _____ **Business Phone:** _____

Insurance Co.: _____ **Member ID#:** _____

Phone: _____ **Group #:** _____

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DENTAL HISTORY

Patient Name: _____

Reason for today's visit: _____

Former Dentist *(if first visit):* _____ **Address:** _____

City: _____ **State:** _____ **Zip:** _____

Date of last dental visit: _____ **Date of last dental xrays:** _____

Please place an (X) on "yes" or "no" to indicate if you have had any of the following:

Bad Breath	☐ Y ☐ N	Jaw pain or tenderness	☐ Y ☐ N	Tobacco use:	
Bleeding Gums	☐ Y ☐ N	Lip or cheek biting	☐ Y ☐ N	*please (x) all that apply*	
Blisters on lips or mouth	☐ Y ☐ N	Loose teeth or broken fillings	☐ Y ☐ N	☐ cigarettes	_____ packs/day
Burning sensation on tongue	☐ Y ☐ N	Mouth breathing	☐ Y ☐ N	☐ cigar	
Chew on one side of mouth	☐ Y ☐ N	Mouth pain, brushing	☐ Y ☐ N	☐ chewing tobacco	
Clicking or popping of jaw	☐ Y ☐ N	Orthodontic treatment	☐ Y ☐ N	☐ pipe	
Dry mouth	☐ Y ☐ N	Pain around ear	☐ Y ☐ N	☐ e-cigarettes	
Fingernail biting	☐ Y ☐ N	Periodontal Treatment	☐ Y ☐ N	☐ vaping	
Food Collection between teeth	☐ Y ☐ N	Sensitivity to: cold ☐ Y ☐ N heat	☐ Y ☐ N	☐ past tobacco user	year quit_____
Grinding teeth	☐ Y ☐ N	sweets ☐ Y ☐ N biting	☐ Y ☐ N	How often do you brush?_____	
Gums swollen or tender	☐ Y ☐ N	Sores or growths in your mouth	☐ Y ☐ N	How often do you floss?_____	

HEALTH HISTORY

Physician Name/phone #: **Date of last visit:**

Please place an (X) on "yes" or "no" to indicate if you have had or currently have any of the following:

AIDS/HIV	☐ Y ☐ N	Eating Disorder	☐ Y ☐ N	Radiation Treatment	☐ Y ☐ N
Alcohol/Drug Recovery	☐ Y ☐ N	Emphysema	☐ Y ☐ N	Respiratory Disease	☐ Y ☐ N
Anemia	☐ Y ☐ N	Epilepsy	☐ Y ☐ N	Sexually Transmitted Disease	☐ Y ☐ N
Arthritis/Rheumatism	☐ Y ☐ N	Fainting or Dizziness	☐ Y ☐ N	Shortness of Breath	☐ Y ☐ N
Artificial Heart Valves	☐ Y ☐ N	Headaches	☐ Y ☐ N	Sinus Trouble	☐ Y ☐ N
Artificial Joints	☐ Y ☐ N	Hearing Impaired	☐ Y ☐ N	Skin Rash	☐ Y ☐ N
Asthma	☐ Y ☐ N	Do you wear Hearing Aides?	☐ Y ☐ N	Snore	☐ Y ☐ N
Autism Spectrum Disorder	☐ Y ☐ N	Heart Murmur	☐ Y ☐ N	Sleep Apnea	☐ Y ☐ N
Autoimmune Disorder	☐ Y ☐ N	Heart Problems	☐ Y ☐ N	Do you use a CPAP?	☐ Y ☐ N
Back Problems	☐ Y ☐ N	Hepatitis Type _____	☐ Y ☐ N	Special Diet	☐ Y ☐ N
Behavioral Disorders	☐ Y ☐ N	Herpes	☐ Y ☐ N	Stroke	☐ Y ☐ N
Please specify: _____		High Blood Pressure	☐ Y ☐ N	Swollen Feet or Ankles	☐ Y ☐ N
Bleeding abnormality with	☐ Y ☐ N	Jaundice	☐ Y ☐ N	Swollen Neck Glands	☐ Y ☐ N
extractions or surgery		Jaw Pain	☐ Y ☐ N	Thyroid Problems	☐ Y ☐ N
Blood Disease	☐ Y ☐ N	Kidney Disease	☐ Y ☐ N	Tonsillitis	☐ Y ☐ N
Cancer	☐ Y ☐ N	Liver Disease	☐ Y ☐ N	Tuberculosis	☐ Y ☐ N
Chemotherapy	☐ Y ☐ N	Low Blood Pressure	☐ Y ☐ N	Tumor or Growth in Head/Neck	☐ Y ☐ N
Circulatory Problems	☐ Y ☐ N	Mitral Valve Prolapse	☐ Y ☐ N	Ulcers	☐ Y ☐ N
Congenital Heart Lesions	☐ Y ☐ N	Osteoporosis	☐ Y ☐ N	Vertigo	☐ Y ☐ N
COPD	☐ Y ☐ N	Pacemaker	☐ Y ☐ N	Vision Impaired	☐ Y ☐ N
Diabetes	☐ Y ☐ N	Psychiatric Care	☐ Y ☐ N	Weight Loss/Unexplained	☐ Y ☐ N

Is there any other condition not listed above? If so, please indicate: _____

Please continue on to next page

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HEALTH HISTORY CONTINUED

PATIENT NAME:

Do you wear contact lenses? ☐ Y ☐ N Have you been told to premedicate for dental treatment? ☐ Y ☐ N

Have you had recent surgery or been hospitalized? ☐ Y ☐ N

Please indicate reason: _____

Women:
Are you pregnant? ☐ Y ☐ N Due Date: _____ Are you nursing? ☐ Y ☐ N

Are you taking Birth Control Pills? ☐ Y ☐ N

ALLERGIES

☐ Codeine or other prescription painkillers ☐ Local Anesthetic ☐ Latex

☐ Antibiotics – Please list: _____

☐ Other – Please list: _____

MEDICATIONS

Preferred Pharmacy Name: _____ **Phone Number:** _____

List all MEDICATIONS (*prescription and over the counter, including vitamins/nutritional supplements*) you are currently taking AND the CORRELATING DIAGNOSIS

MEDICATIONS	CORRELATING DIAGNOSIS

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge and that it is my responsibility to inform this office of any changes in my/my child's medical status. I authorize the dental staff to perform the necessary dental services for my minor/child. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

Signature: _____ Date: _____

Relationship to patient *(if minor or guardian/caretaker)*: _____

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