Welcome

Please fill out front & back sides of this questionnaire.

About You

Name: _____ SS#_____ Sex: _____

D.O.B.:_____ Age: _____ Marital Status: _____ Cell # _____

Email _____ Text Messages OK? ☐ YES ☐ NO (check one)

Home # _____ Work # _____ Pharmacy # _____

Home Address: _____ Town and Zip Code _____

Employer: _____

Emergency Contact

Name: _____ Phone#_____

1. Spouse Information

His/Her Name: _____ SS#_____D.O.B: _____

Employer: _____ Work # _____

2. Dental Concerns

What is the reason for today's visit?_____

Do you have any questions/concerns about any other teeth? _____

How many times a day do you brush?_____ Floss? _____

Do you use tobacco products? _____

Why did you leave your last Dentist? _____

When was your last dental visit? _____

Whom may we thank for referring you? _____

2. Payment Options - check one (To inlcude Insurance Deductibles and Co-Payments)

☐ No interest monthly payment plan (with credit check)

☐ Credit Card: ☐ Visa ☐ MC ☐ Discover ☐ American Express _____

☐ Cash or Check _____

(OVER)

4. Medical History

Check any of the following you have had or suspected.

- ☐ Anemia / Radiation Treatment
- ☐ Artificial Bones / Joints
- ☐ Epilepsy / Seizures / Fainting Spells
- ☐ Asthma / Arthritis
- ☐ Blood Transfusion
- ☐ Cancer / Chemotherapy
- ☐ Congenial Heart Defect
- ☐ Hemophilia / Abnormal Bleeding
- ☐ Difficulty Breathing
- ☐ Drug / Alcohol Abuse
- ☐ Emphysema / Glaucome
- ☐ Fever Blistes / Herpes
- ☐ Artificial Valves
- ☐ Heart Attacks / Strokes
- ☐ Heart Murmur
- ☐ Heart Surgery / Pacemaker
- ☐ Hepatitis A B C
- ☐ Diabetes / Tuberculosis
- ☐ Ulcer / Colitis
- ☐ HIV+ / AIDS
- ☐ Hospitalized for any Reason
- ☐ Kidney Problems
- ☐ Mitral Valve Prolapse
- ☐ Psychiatric Problems
- ☐ Rheumatic / Scarlet Fever
- ☐ Severe / Frequent Headache
- ☐ Shingles
- ☐ Sinus Problems
- ☐ High / Low Blood Pressure
- ☐ Venereal Disease

Please list all medications / vitamins you are taking: _____

_____

_____

Check off any of the following you may be allergic to :

- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Erythromycin
- ☐ Latex
- ☐ Penicillin
- ☐ Tetracycline
- ☐ Lead or Metal Alloys
- ☐ Other _____

Are you under the care of a physician: ☐ YES ☐ NO

If yes, please explain _____

_____

Female patients, are you pregnant?: ☐ YES ☐ NO

If yes, due date _____

I authorize and give consent to perform dental services agree between doctor and patient and/ or parent or guardian to be necessary of advisable including the use of local anesthesia and other medications as indicated. I certify to the above statements regarding my medical condition. I also understand that it is my responsiblity to inform this office of any changes in my medical status.

Patient's Signature _____ Date: _____

Parent or guardian _____ Date: _____

(If patient is child or requires a guardian)