

Patient Questionnaire

Patient Information

Patient Name: _____ Date: _____
Last First MI (Preferred Name)

Birth Date: _____ Gender: _____ Family Status (Married/Single/Child): _____

Other

Social Security #: _____ E-Mail: _____

Phone (Home): _____ (Work): _____ (Cell): _____

Address: _____
Street Apartment #

City State Zip

Spouse name and work phone number: _____

Emergency name and phone number: _____

Whom may we thank for referring you to our practice? _____

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No
Last First MI

Insured's Birth Date: _____ ID #: _____ SS#: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Group Name: _____

Address: _____ Phone #: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No
Last First MI

Insured's Birth Date: _____ ID #: _____ SS#: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Group Name: _____

Address: _____ Phone #: _____

Patient Questionnaire

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____
Last Name
First Name
Middle Initial

Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____

Address: _____
Street
Apartment #

City
State
Zip Code

Dental Health Information

Please mark any that apply:

- | | |
|---|--|
| <p>Are you apprehensive about dental treatment? _____</p> <p>Have you had problems with previous dental treatment? _____</p> <p>Do you gag easily? _____</p> <p>Do you wear dentures? _____</p> <p>Does food catch between your teeth? _____</p> <p>Do you have difficulty in chewing your food? _____</p> <p>Do you chew on only one side of your mouth? _____</p> <p>Do you avoid brushing any part of your mouth because of pain? _____</p> <p>Do your gums bleed easily? _____</p> <p>Do your gums bleed when you floss? _____</p> <p>Do your gums feel swollen or tender? _____</p> <p>Have you ever noticed slow-healing sores in or about your mouth? _____</p> <p>Are your teeth sensitive? _____</p> <p>Do you feel twinges of pain when your teeth come in contact with:</p> <p style="padding-left: 20px;">Hot food or liquids? _____</p> <p style="padding-left: 20px;">Cold foods or liquids? _____</p> <p style="padding-left: 20px;">Sours? _____</p> <p style="padding-left: 20px;">Sweets? _____</p> <p>Do you take fluoride supplements? _____</p> <p>Are you dissatisfied with the appearance of your teeth? _____</p> <p>Do you prefer to save your teeth? _____</p> <p>Do you want complete dental care? _____</p> | <p>How often do you brush? _____</p> <p>How often do you floss? _____</p> <p>Does your jaw make noise so that it bothers you or others? _____</p> <p>Do you clench or grind your jaws frequently? _____</p> <p>Do your jaws ever feel tired? _____</p> <p>Does your jaw get stuck so that you can't open freely? _____</p> <p>Does it hurt when you chew or open wide to take a bite? _____</p> <p>Do you have earaches or pain in front of the ears? _____</p> <p>Do you have any jaw symptoms or headaches upon awaking in the morning? _____</p> <p>Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities? _____</p> <p>Do you find jaw pain or discomfort extremely frustrating or depressing? _____</p> <p>Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)? _____</p> <p>Do you have a temporomandibular (jaw) disorder (TMD, TMJ)? _____</p> <p>Do you have pain in the face, cheeks, jaws, joints, throat, or temples? _____</p> <p>Are you unable to open your mouth as far as you want? _____</p> <p>Are you aware of an uncomfortable bite? _____</p> <p>Have you had a blow to the jaw (trauma)? _____</p> <p>Are you a habitual gum chewer or pipe smoker? _____</p> |
|---|--|

Patient Questionnaire

Medical Healthy History

Please check those that apply:

Heart Problems:

- Chest pain _____
- Shortness of breath _____
- Blood pressure problem _____
- Heart murmur _____
- Heart valve problem _____
- Taking heart medication _____
- Rheumatic fever _____
- Pacemaker _____
- Artificial heart valve _____

- Fainting spells, seizures or epilepsy _____
- Stroke(s) _____
- Frequent or severe headaches _____
- Thyroid problems _____
- Persistent cough or swollen glands _____
- Premedications required by physician _____
- Cancer/Tumor _____
- Diabetes _____
- Urinate more than 6 times a day _____
- Thirsty or mouth is dry much of the time _____

Blood Problems:

- Easy bruising _____
- Frequent nosebleeds _____
- Abnormal bleeding _____
- Blood disease (anemia) _____
- Ever require a blood transfusion? _____

- Family history of diabetes _____
- Tuberculosis or other respiratory disease _____
- Do you drink alcohol? _____
- If so, how much? _____
- Do you smoke? _____
- If so, how much? _____

Allergy Problems:

- Hay fever _____
- Sinus problems _____
- Skin rashes _____
- Taking allergy medication _____
- Asthma _____

- Hepatitis, jaundice, or liver trouble? _____
- Herpes or other STD _____
- HIV-positive/AIDS _____
- Glaucoma _____
- Do you wear contact lenses? _____
- History of head injury? _____

Intestinal Problems:

- Ulcers _____
- Weight gain or loss _____
- Special diet _____
- Constipation/Diarrhea _____
- Kidney or bladder problems _____

- Epilepsy or other neurological disease? _____
- History of alcohol or drug abuse? _____
- Do you have any disease, condition, or problem not listed previously that you feel we should know about? _____
- If so, please describe _____

Bone or joint Problems:

- Arthritis _____
- Back or neck pain _____
- Joint replacement (e.g. total hip, pins, or implants) _____

During the past 12 months, have you taken any of the following?

- Antibiotics or sulfa drugs _____
- Anticoagulants (e.g. Coumadin) _____
- High blood pressure medicine _____
- Tranquilizers _____
- Insulin, Orinase, or similar drug _____
- Aspirin _____
- Digitalis or drugs for heart trouble _____
- Nitroglycerin _____
- Cortisone (steroids) _____
- Natural remedies _____
- Nonprescription drugs/supplements _____
- Other _____

Are you allergic, or have you reacted adversely, to any of the following?

- Local anesthetics ("Novocaine") _____
- Penicillin or other antibiotics _____
- Sulfa drugs _____
- Barbiturates, sedatives, or sleeping pills _____
- Aspirin, Acetaminophen, or Ibuprofen _____
- Codeine, Demerol, or other narcotics _____
- Reaction to metals _____
- Latex or rubber dam _____
- Other _____

Women Only

- Are you taking contraceptives or other hormones? _____
- Are you nursing? _____

- Are you pregnant? _____
- If so, expected delivery date: _____
- Have you reached menopause? _____
- If so, do you have any symptoms? _____

