HEALTH QUESTIONAIRE

Date: _____ E-mail Address: _____

Name: _____ Marital Status: S / M / D / W

Address: _____

City: _____ State: _____ Zip: _____

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

Work Phone: (_____) _____ Occupation: _____

Social Security Number: _____ Date of Birth: _____

Person to contact in case of Emergency: _____

Relationship to patient: _____ Daytime telephone number (_____) _____

GETTING TO KNOW YOU
How were referred to our office? ☐ Relative ☐ Friend ☐ Insurance Company ☐ Other
If Relative or Friend please name:

IN ORDER FOR US TO BE ABLE TO PROCESS YOUR INSURANCE, PLEASE COMPLETE ALL OF THE FOLLOWING INFORMATION:

PRIMARY DENTAL INSURANCE COVERAGE

Subscriber Name: _____ Relationship to Patient: _____

Address: _____

Social Security Number: _____ Employer: _____

Date of Birth: _____ Address: _____

Plan Name: _____ Group No: _____

Insurance Company: _____ Address: _____

SECONDARY DENTAL INSURANCE COVERAGE

Subscriber Name: _____ Relationship to Patient: _____

Address: _____

Social Security Number: _____ Employer: _____

Date of Birth: _____ Address: _____

Plan Name: _____ Group No: _____

Insurance Company: _____ Address: _____

Last Dental Visit: _____ Last X-Ray: _____ Last Cleaning: _____

What is your main dental concern? _____

Are you anxious about today's visit? ☐ Yes ☐ No

If yes, what can we do to make you more comfortable? _____

Have you had braces? ☐ Yes ☐ No If yes, when? _____

Have you had gum treatment? ☐ Yes ☐ No If yes, when? _____

THIS QUESTIONAIRE WILL BE USED BY THE DENTIST TO HELP TREAT YOU SAFELY. PLEASE ANSWER ALL QUESTIONS AS ACCURATLEY AS POSSIBLE.

Do you have a history of any of the following: Please circle Yes or No

High Blood Pressure	Y	N	Have you had a blood transfusion?	Y	N	Mentally Disabled	Y	N
Low Blood Pressure	Y	N	Rheumatic Fever	Y	N	Liver Disease	Y	N
Diabetes	Y	N	Heart Murmur	Y	N	Glaucoma	Y	N
Asthma	Y	N	Mitral Valve Prolapse	Y	N	Thyroid Disease	Y	N
Emphysema	Y	N	Stomach Ulcers	Y	N	Epilepsy (Seizures)	Y	N
Cancer	Y	N	Psychiatric Treatment	Y	N	Prosthetic Heart Valve	Y	N
Chemotherapy	Y	N	Tuberculosis	Y	N	Artificial Joints or Organs?	Y	N
Radiation Treatment	Y	N	AIDS or HIV	Y	N	Are you allergic to latex?	Y	N
Heart Disease	Y	N	Sexually Transmitted Disease	Y	N	Do you use tobacco?	Y	N
Heart Attack	Y	N	Kidney Disease	Y	N	Packs Per Day _____		
Stroke	Y	N	Hepatitis B	Y	N	How Long _____		
Bleeding Problems	Y	N	Hepatitis C	Y	N			
Anemia	Y	N	Developmental Delay	Y	N			
Blood Disease	Y	N						
Blood Thinners	Y	N						

Are you addicted to or recovering from Drugs and/or Alcohol? ☐ Yes ☐ No

Do have you have any condition or problem not listed? ☐ Yes ☐ No If yes please list _____

Have you had any of the following in the past year? Please circle Yes or No

Shortness of breath with mild exercise?	Y	N
Shortness of breath while lying down?	Y	N
Chest Pains?	Y	N
Persistent cough or coughing up blood?	Y	N
Severe heat or cold tolerance?	Y	N
Frequent urination or increase thirst?	Y	N
Diet Pills	Y	N

Medical Doctor's Name & Address: _____

Date & Reason for last visit: _____

Name of Previous Dentist: _____ **Telephone:** _____