QUESTIONNAIRE/MEDICAL HISTORY – ADULT

Patient Name: ____ Date of Birth: ______________________
Address: ______________________________________ City: ______________________State: _____ Zip: ____________
Phone Number: __________________________________ Work Phone: ____
Other Phone: _____________________________________ Email: ____
Whom may we thank for your referral or how did you find us? ____

RESPONSIBLE PARTY
Name of person responsible for this account: ___________________________________Relationship: ________________
Billing address (if different from above): ____
Responsible phone number: _____________________________________Responsible SS#: __________________________
Phone number for appointment confirmations: ____

* Please be aware that the person who brings in the child is ultimately responsible for consent and final payment. We understand some of our patients have legal agreements with a former spouse, etc. If this is your case, then you must bring in a notarized letter as such or you will be responsible.
Please initial here that you have read the above paragraph and understand it. X ______________________________

INSURANCE INFORMATION

Name of insured: ____Relationship:______________________
Birth date: ____________________SS#: ___________________________
Name of employer: ____ Date of employment:___________________
Address of employer: ____________________________________City: ________________State: ______ Zip: ___________
Work #: _____________________Union or Local #: ______________
Insurance company: _________________________________Group #: ________________ ID #: _____________________
Insurance company address: ____________________________City: _______________State: _____ Zip: ___________
How much is your deductible? ____________ How much have you used? ______________ Max benefit _____________

* I authorize the dentist to release any information including the diagnosis and the records of any treatment of examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group for insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I also understand that insurance estimates are just that and may reflect inaccurate information. It is my responsibility to inform the office of any and all changes to my insurance.
Please initial here that you have read the above paragraph and understand it. X ______________________________

MEDICAL HISTORY

Patient Date of Birth: ____________________
Physician's name: ____________________________________Physician's Phone: ____________________________
1. Have you had any medical care within the past two years? (Please circle) Yes / No
If so, describe: ____
2. Have you taken any medication or drugs during the past two years? Yes / No
If yes, please list: ____
3. Are you currently taking any medications, drugs, pills, or herbal remedies, including regular dosages of aspirin? Yes / No
If yes, please list: ____
4. Have you ever taken prescription medications for weight loss (diet pills)? Yes / No
If yes, did you take any of the following? (Please circle) Fen-Phen Pondimen Redux Other ___________
If yes to any of the above, did you have a medical exam for heart issues? Yes / No

(CONTINUED ON NEXT PAGE)

5. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva, or other similar drugs? Yes / No
6. Have you been in the hospital during the past five years? Yes / No
If yes, please specify: ____
7. Are you allergic to any of the following? (Please circle)
Aspirin Penicillin Amoxicillin Latex Local Anesthetics Gluten Metal
Please list any other substances/medications you have had allergic or adverse reaction to:
____
8. Please check Yes or No to each item below:

Do you have, or have you had, any of the following?

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
AIDS/HIV Positive	◯ Yes	◯ No	Cortisone Medicine	◯ Yes	◯ No	Hemophilia	◯ Yes	◯ No	Radiation Treatments	◯ Yes	◯ No
Alzheimer's Disease	◯ Yes	◯ No	Diabetes	◯ Yes	◯ No	Hepatitis A	◯ Yes	◯ No	Recent Weight Loss	◯ Yes	◯ No
Anaphylaxis	◯ Yes	◯ No	Drug Addiction	◯ Yes	◯ No	Hepatitis B or C	◯ Yes	◯ No	Renal Dialysis	◯ Yes	◯ No
Anemia	◯ Yes	◯ No	Easily Winded	◯ Yes	◯ No	Herpes	◯ Yes	◯ No	Rheumatic Fever	◯ Yes	◯ No
Angina	◯ Yes	◯ No	Emphysema	◯ Yes	◯ No	High Blood Pressure	◯ Yes	◯ No	Rheumatism	◯ Yes	◯ No
Arthritis/Gout	◯ Yes	◯ No	Epilepsy or Seizures	◯ Yes	◯ No	High Cholesterol	◯ Yes	◯ No	Scarlet Fever	◯ Yes	◯ No
Artificial Heart Valve	◯ Yes	◯ No	Excessive Bleeding	◯ Yes	◯ No	Hives or Rash	◯ Yes	◯ No	Shingles	◯ Yes	◯ No
Artificial Joint	◯ Yes	◯ No	Excessive Thirst	◯ Yes	◯ No	Hypoglycemia	◯ Yes	◯ No	Sickle Cell Disease	◯ Yes	◯ No
Asthma	◯ Yes	◯ No	Fainting Spells/Dizziness	◯ Yes	◯ No	Irregular Heartbeat	◯ Yes	◯ No	Sinus Trouble	◯ Yes	◯ No
Blood Disease	◯ Yes	◯ No	Frequent Cough	◯ Yes	◯ No	Kidney Problems	◯ Yes	◯ No	Spina Bifida	◯ Yes	◯ No
Blood Transfusion	◯ Yes	◯ No	Frequent Diarrhea	◯ Yes	◯ No	Leukemia	◯ Yes	◯ No	Stomach/Intestinal Disease	◯ Yes	◯ No
Breathing Problems	◯ Yes	◯ No	Frequent Headaches	◯ Yes	◯ No	Liver Disease	◯ Yes	◯ No	Stroke	◯ Yes	◯ No
Bruise Easily	◯ Yes	◯ No	Genital Herpes	◯ Yes	◯ No	Low Blood Pressure	◯ Yes	◯ No	Swelling of Limbs	◯ Yes	◯ No
Cancer	◯ Yes	◯ No	Glaucoma	◯ Yes	◯ No	Lung Disease	◯ Yes	◯ No	Thyroid Disease	◯ Yes	◯ No
Chemotherapy	◯ Yes	◯ No	Hay Fever	◯ Yes	◯ No	Mitral Valve Prolapse	◯ Yes	◯ No	Tonsillitis	◯ Yes	◯ No
Chest Pains	◯ Yes	◯ No	Heart Attack/Failure	◯ Yes	◯ No	Osteoporosis	◯ Yes	◯ No	Tuberculosis	◯ Yes	◯ No
Cold Sores/Fever Blisters	◯ Yes	◯ No	Heart Murmur	◯ Yes	◯ No	Pain in Jaw Joints	◯ Yes	◯ No	Tumors or Growths	◯ Yes	◯ No
Congenital Heart Disorder	◯ Yes	◯ No	Heart Pacemaker	◯ Yes	◯ No	Parathyroid Disease	◯ Yes	◯ No	Ulcers	◯ Yes	◯ No
Convulsions	◯ Yes	◯ No	Heart Trouble/Disease	◯ Yes	◯ No	Psychiatric Care	◯ Yes	◯ No	Venereal Disease	◯ Yes	◯ No
									Yellow Jaundice	◯ Yes	◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes [ ]

9. Women: Are you pregnant or think you could be pregnant? Yes / No ________Months Nursing? Yes / No
10. Do you use birth control prescriptions? Yes / No If yes, please specify: ________________________________
Comments:____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dentist/dental office of any changes in medical status.

Signature of patient, parent, or guardian:

X ____ Date: ___________________

____
(Print Name)

____ Date: ______________
(Dentist Signature)

____ Date: _______________
(Hygientist Signature)

Patient Name

Patient Account No.

DENTAL HISTORY

Medical Alert

Welcome! Please complete both sides of this dental/medical history form so that we may provide you with the best possible dental care.
All information is completely confidential.

What is the reason for your visit today? ______

Date of Last Dental Visit? ______ Last Dental Cleaning ______ Last Full Mouth X-rays ______
What was done at your last dental visit? ______
Previous Dentist's Name ______ Telephone ______
Address ______ State ______ Zip ______
How often do you have dental examinations? ______
How often do you brush your teeth? ______ How often do you floss? ______
Have you ever used or are you currently using topical fluoride? ☐ Yes ☐ No
What other dental aids do you use (interplak, toothpick, etc.)? ______
Do you have any dental problems now? ☐ Yes ☐ No
If yes, please describe: ______

Are any of your teeth sensitive to:

- Hot or cold? ☐ Yes ☐ No
- Sweets? ☐ Yes ☐ No
- Biting or chewing? ☐ Yes ☐ No
- Have you noticed any mouth odors or bad taste? ☐ Yes ☐ No
- Do you frequently get cold sores, blisters or any other oral lesions? ☐ Yes ☐ No
- Do your gums bleed or hurt? ☐ Yes ☐ No
- Have your parents experienced gum disease or tooth loss? ☐ Yes ☐ No
- Have you noticed any loose teeth or change in your bite? ☐ Yes ☐ No
- Does food tend to become caught in between your teeth? ☐ Yes ☐ No

If yes, where? ______

Do you:

- Clench or grind your teeth while awake or asleep? ☐ Yes ☐ No
- Bite your lips or cheeks regularly? ☐ Yes ☐ No
- Hold foreign objects with your teeth (pencils, pipe, pins, nails, fingernails)? ☐ Yes ☐ No
- Mouth breathe while awake or asleep? ☐ Yes ☐ No
- Have tired jaws, especially in the morning? ☐ Yes ☐ No
- Snore or have any other sleeping disorders? ☐ Yes ☐ No
- Smoke/chew tobacco or use other tobacco products? ☐ Yes ☐ No

Have you ever had:

- Orthodontic treatment? ☐ Yes ☐ No
- Oral surgery? ☐ Yes ☐ No
- Periodontal treatment? ☐ Yes ☐ No
- Your teeth ground or the bite adjusted? ☐ Yes ☐ No
- A bite plate or mouth guard? ☐ Yes ☐ No
- A serious injury to the mouth or head? ☐ Yes ☐ No

If yes, please describe, including cause ______

Have you experienced:

- Clicking or popping of the jaw? ☐ Yes ☐ No
- Pain (joint, ear, side of face)? ☐ Yes ☐ No
- Difficulty in opening or closing the mouth? ☐ Yes ☐ No
- Difficulty in chewing on either side of the mouth? ☐ Yes ☐ No
- Headaches, neck aches or shoulder aches? ☐ Yes ☐ No
- Sore muscles (neck, shoulders)? ☐ Yes ☐ No
- Are you satisfied with your teeth's appearance? ☐ Yes ☐ No
- Would you like to keep all of your teeth all of your life? ☐ Yes ☐ No
- Do you feel nervous about having dental treatment? ☐ Yes ☐ No

If so, what is your biggest concern? ______

- Have you ever had an upsetting dental experience? ☐ Yes ☐ No

If yes, please describe ______

Have you ever been told to take a pre-medication prior to dental treatment? ☐ Yes ☐ No
Is there anything else about having dental treatment that you would like us to know? ☐ Yes ☐ No
If yes, please describe ______

PLEASE COMPLETE OTHER SIDE