# Medical Health Questionnaire

## PERSONAL INFORMATION

Last Name_____First_____MI_____Preferred Name_____
Address_____City_____State_____Zip Code_____
Home # (_____)_____Work # (_____)_____Cell # (_____)_____
Please Circle Preferred Number E-Mail_____
Date of Birth___/___/___ Sex: M F Social Security # _____-_____-_____
Occupation _____
☐ Single ☐ Married / Spouse's Name_____ ☐ Widowed ☐ Separated ☐ Divorced

Emergency Contact_____Relationship_____Phone (_____)_____

## REFERRAL INFORMATION

Whom may we thank for referring you to our practice?
☐ Another patient; friend, relative ☐ Another Dental Office ☐ Yellow Pages ☐ Other_____
Name of person or office referring you to our practice:_____

## HEALTH HISTORY

Physician's Name_____Physician's Phone (_____)_____
Date of last visit_____/____/____

Please circle **Y** (Yes) or **N** (No) to indicate if you had any of the following and if yes, provide date:

**Y N** Abnormal bleeding w/ Extraction/surgery
**Y N** Aids
**Y N** Anemia
**Y N** Arthritis, Rheumatism
**Y N** Artificial Heart Valves
**Y N** Artificial Joints
**Y N** Asthma
**Y N** Autoimmune Disease
**Y N** Back Problems
**Y N** Blood Disease
**Y N** Cancer
**Y N** Chemical Dependency
**Y N** Chemotherapy
**Y N** Circulatory Problems
**Y N** Congenital Heart Lesions
**Y N** Cortisone Treatments
**Y N** Cough, persistent or bloody
**Y N** Diabetes
**Y N** Emphysema
**Y N** Epilepsy
**Y N** Fainting / Dizziness
**Y N** Glaucoma
**Y N** Headaches
**Y N** Heart Murmur
**Y N** Heart Problems
**Y N** Hepatitis: Type _____
**Y N** Herpes
**Y N** High Blood Pressure
**Y N** HIV Positive
**Y N** Jaundice
**Y N** Jaw Pain
**Y N** Kidney Disease
**Y N** Liver Disease
**Y N** Low Blood Pressure
**Y N** Mitral Valve Prolapse
**Y N** Nervous Problems
**Y N** Neurological Problems
**Y N** Osteoporosis
**Y N** Pace Maker
**Y N** Prosthetic Device
**Y N** Psychiatric Care
**Y N** Radiation Treatment
**Y N** Recent Surgeries
**Y N** Sinus Trouble
**Y N** Skin Rash
**Y N** Smoke (cigarette, cigar, pipe)
**Y N** Smokeless Tobacco
**Y N** Special Diet
**Y N** Stroke
**Y N** Swelling of Feet or Ankles
**Y N** Swollen Neck Glands
**Y N** Thyroid Problems
**Y N** Tonsillitis
**Y N** Tuberculosis
**Y N** Venereal Disease
**Y N** Weight Loss, unexplained

**Women Only:**
**Y N** Oral Contraceptives
**Y N** Are you pregnant?
Due Date __/__/__
**Y N** Are you nursing?

## MEDICATIONS

List all medications you are currently taking:_____
_____
_____

Do you premedicate before dental visits? **Y N**
If so, name of antibiotic taken: _____

## ALLERGIES

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Y** | **N** | Aspirin | **Y** | **N** | Latex | **Y** | **N** | Penicillin | Other: |
| **Y** | **N** | Barbiturates | **Y** | **N** | Local Anesthetic | Other Antibiotics: | | | _____ |
| **Y** | **N** | Codeine | **Y** | **N** | Sulfa | _____ | | | _____ |

## DENTAL HISTORY

Reason for todays visit: _____
Former Dentist _____City_____State_____
Date of Last Dental Visit ____/____/____

Please circle **Y** (Yes) or **N** (No) to indicate if you have had any of the following.

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Y** | **N** | Bad Breath | **Y** | **N** | Grinding / Clenching of teeth | **Y** | **N** | Sensitivity to Cold | |
| **Y** | **N** | Bleeding Gums | **Y** | **N** | Gums swollen or tender | **Y** | **N** | Sensitivity to Heat | |
| **Y** | **N** | Blisters on lips or mouth | **Y** | **N** | Jaw pain or tiredness | **Y** | **N** | Sensitivity to Sweets | |
| **Y** | **N** | Broken filling | **Y** | **N** | Lip or cheek biting | **Y** | **N** | Sensitivity when Biting | |
| **Y** | **N** | Burning Sensation on tongue | **Y** | **N** | Loose Teeth | **Y** | **N** | Sores or Growths in Mouth | |
| **Y** | **N** | Clicking or popping of jaw | **Y** | **N** | Mouth Breather | | | | |
| **Y** | **N** | Do you wear any removable dental appliances? | **Y** | **N** | Orthodontic Treatment | When do you Brush? | | AM | PM |
| | | | **Y** | **N** | Pain around Ear | When do you Floss? | | AM | PM |
| **Y** | **N** | Dry Mouth | **Y** | **N** | Pain when brushing teeth | | | | |
| **Y** | **N** | Food traps between teeth | **Y** | **N** | Periodontal (Gum) Treatment | | | | |

## DENTAL INSURANCE

Who is responsible for this account?_____ Birthdate_____/_____/_____
Social Security Number _____-_____-_____ Relationship to Patient_____
Employer_____
Insurance Company _____ Group Number_____
Is patient covered by additional insurance? ☐ Yes ☐ No If so, please continue.
Subscriber's Name _____ Birthdate_____/____/_____
Social Security Number _____-_____-_____ Relationship to Patient_____
Insurance Company _____ Group Number_____

**Assignment and Release:**
I, the undersigned certify that I (or my dependents) have insurance coverage with _____ and assign directly to Dr._____ all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.
Signature of Responsible Party _____ Date ____/____/____
Relationship to Patient_____
**NOTE:** Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient / Legal Guardian _____ Date____/____/____

Signature of Doctor_____