

PLEASE PRINT

Patient Questionnaire

Patient's Name: _____ Male or Female Age _____ Birth date _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Driver's Lic # _____ Social Security # _____

Employer _____ Work Phone # _____

Business Address _____ City _____ State _____ Zip _____

Marital Status, please circle: single married divorced separated

If patient is a student, name of School or College: _____

Person to contact in case of Emergency: _____ Phone # _____

What is your dental problem? _____

Name of your regular dentist: _____ Phone # _____

Name of your regular physician: _____ Phone # _____

Who referred you to our office? _____

Note: For patients 62 or older: Are you eligible for Medicare (circle one) Yes No
(Please be advised that services related to teeth and gums are not covered by Medicare)

Insurance Information:

Name of Insured _____ Date of Birth _____ Social Security # _____

Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Relationship to patient, please circle: self spouse parent other: _____

If patient is a dependent child, are the legal parents separated or divorced? Yes No

Insurance Company _____ Group No./ Plan No. _____

Address _____ City _____ State _____ Zip _____

Insurance Company Phone _____

Financially Responsible Party: Relationship to patient, please circle: self spouse parent other: _____

Name: _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Phone # _____ Cell # _____ Driver's Lic.# _____

Employer _____ Work Phone # _____

Fees and Payment

We make every effort to keep down the cost of your oral surgical care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms but please complete the identifying information at the top of the form. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by the insurance company. This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment directly to the dentist named of the insurance benefits otherwise payable to me.

Signature: _____

Please complete reverse side

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Health History

Patient's Name _____ Height _____ Weight _____

- Circle Yes No
1. Are you having any oral pain, discomfort or problem at this time? Yes No
If due to an accident, what type? _____
2. Are you under the care of a medical doctor? Yes No
If yes, for what reason? _____
3. Are you taking any medication at the present time, including birth control pills, non-prescription medications or herbal supplements? Yes No
If yes, please list: _____
4. Are you taking or have you ever taken bisphosphonates or biologics for osteoporosis, multiple myeloma or autoimmune disease? Yes No
Fosamax, Actonel, Boniva, Aredia, Zometa, Reclast, Prolia, Humira, Enbrel or other: _____
5. Are you allergic to latex, eggs, soy or any medication or drug? Yes No
If yes, please list: _____
6. Have you ever had an unusual reaction to Novocaine or any anesthetic? Yes No
7. Have you ever been a patient in the hospital? Yes No
If yes, please list approximate date(s) and reason(s): _____
8. Have you ever had any excessive bleeding requiring special treatment? Yes No
9. Please circle a Y or N answer to each condition:
- | | | |
|------------------------------|---------------------------------------|------------------------------------|
| Y N High blood pressure | Y N Fainting or dizzy spells | Y N Kidney disease |
| Y N Chest pain | Y N Stroke | Y N Stomach ulcer |
| Y N Shortness of breath | Y N Epilepsy or seizures | Y N Thyroid disease |
| Y N Heart attack | Y N Asthma | Y N Diabetes or high blood sugar |
| Y N Heart failure | Y N Emphysema | Y N Cortisone or steroid treatment |
| Y N Heart pacemaker | Y N Tuberculosis or TB | Y N Glaucoma |
| Y N Artificial heart valve | Y N Liver disease or hepatitis | Y N Artificial joints |
| Y N Heart surgery | Y N Bruise easily | Y N Cancer or tumors |
| Y N Congenital heart disease | Y N Hemophilia | Y N X-ray or radiation treatment |
| Y N Rheumatic fever | Y N Sickle cell disease or trait | Y N Psychiatric treatment |
| Y N Heart murmur | Y N Anemia | Y N History of drug abuse |
| Y N Sleep Apnea | Y N HIV or immunosuppressive disorder | Y N Popping or clicking of the jaw |
10. Do you have any condition and/or health concern not covered above? Yes No
If yes, please describe: _____
11. Do you smoke or use tobacco products? Yes No
If yes, amount and length of use: _____
12. Do you consume alcoholic beverages? Yes No
If yes, amount and frequency of use: _____
13. WOMEN: Are you pregnant now? Yes No
Do you anticipate becoming pregnant? Yes No

Date _____

Signature of patient, parent or guardian _____