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 # _____

Email Address: _____

Employer _____ Work Phone #_____

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

PLEASE PRINT

Health History

Patient's Name _____ Height _____ Weight _____

		Circle	
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

Rev.06/20