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PRACTICE LIMITED TO PERIODONTICS, IMPLANTS, & ORAL MEDICINE

PATIENT QUESTIONNAIRE

(PLEASE FILL OUT BOTH SIDES**)**

Today's Date ______________________ Email ______________________

PATIENT ____
(MR. MRS. MISS) FIRST MIDDLE LAST

Date of Birth ______________ Age ________ Phone: H ______________ W ______________

Residence Address ______________________ City & Zip # ______________

Employed by ______________________ Address ______________________

Occupation ______________________

Full Name of Spouse ______________________

Employed by ______________________ Address ______________________

Occupation ______________________

If Dental Insurance, Name of Company ______________________

Group # ______________ Union local # ______________ Soc. Sec # ______________

If unmarried, Name and Address of Nearest Relative ______________________

Referred By ______________________

Do You Have a Dental Problem at This Time? ______________________

Have you previously been a patient in this office? Yes ☐ No ☐

If so, year of last visit ______________________

Patient's Social Security # ______________ Patient's Driver License # ______________

MEDICAL HEALTH: In order to help me render the proper dental care to you, would you please answer the following questions. Please note the space for remarks for any answers that require clarification or any of the information you think I should have. Thank you for your cooperation.

General Health (Please check) EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐

Name and address of physician ______________________

Last complete physical? ______________ Height ________ Weight ________

Do you have or have you had any of the following diseases or problems?

Heart Disease .... Yes ☐ No ☐
Rheumatic fever .... Yes ☐ No ☐
Congenital heart lesions .... Yes ☐ No ☐
Heart Murmur .... Yes ☐ No ☐
Abnormal blood pressure .... Yes ☐ No ☐
Ulcers .... Yes ☐ No ☐
Tuberculosis or lung disease .... Yes ☐ No ☐
Diabetes .... Yes ☐ No ☐
Epilepsy .... Yes ☐ No ☐
Anemia .... Yes ☐ No ☐
Fainting spells, fits or seizures .... Yes ☐ No ☐

Artificial implants or grafts .... Yes ☐ No ☐
Asthma or hay fever .... Yes ☐ No ☐
Sinus trouble .... Yes ☐ No ☐
Chronic Cough .... Yes ☐ No ☐
Hepatitis, Jaundice or Liver Disease .... Yes ☐ No ☐
Arthritis .... Yes ☐ No ☐
Stroke .... Yes ☐ No ☐
Glaucoma .... Yes ☐ No ☐
Kidney trouble .... Yes ☐ No ☐
Sexually transmitted disease .... Yes ☐ No ☐
AIDS, ARC or HIV Positive .... Yes ☐ No ☐

Have you ever been told to take antibiotics for a dental cleaning? Yes ☐ No ☐

Are you allergic or have you reacted adverseley to:

Local anesthetics .... Yes ☐ No ☐
Penicilin or other antibiotics .... Yes ☐ No ☐
Sulfa Drugs .... Yes ☐ No ☐
Aspirin .... Yes ☐ No ☐

Barbiturates, sedatives or sleeping pills .... Yes ☐ No ☐
Codeine .... Yes ☐ No ☐
Other ____________________

Have you taken any bisphosphonates? Yes ☐ No ☐

Are you taking aspirin on a daily basis? Yes ☐ No ☐

ARE YOU TAKING ANY MEDICATION NOW? Yes ☐ No ☐

NAME OF AND FOR WHAT PURPOSE? ____________________

Are you subject to prolonged bleeding? Yes ☐ No ☐ Please explain ____________________

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Do you have excessive urination and/or thirst? .... Yes ☐ No ☐

Any unusual weight change in the last 3 months? .... Yes ☐ No ☐

Have you had any serious illness, operation or been hospitalized within the past 5 years? .... Yes ☐ No ☐

If so, what was the illness or operation ____________________

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Have you had any serious trouble associated with any previous dental treatment? Yes ☐ No ☐

Do you have disease, condition, or problem not listed above that you think I should know about? Yes ☐ No ☐

Explain ____________________

Do you smoke cigarettes or chew tobacco? .... Yes ☐ No ☐

WOMEN Are you pregnant? .... Yes ☐ No ☐ Due Date ____________________

I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments have not been received by the agreed upon dates, I understand that a one and one half percent finance charge (18%APR) will be added to my account, and I agree to pay it.

I understand and agree that where appropriate, credit bureau reports may be obtained.

Patient ____________________ Date ____________________

Parent or Responsible Party ____________________ Relationship to Patient ____________________

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