ALL INFORMATION IS CONFIDENTIAL

WELCOME TO OUR OFFICE The following information is required by us to assist in proper diagnosis and treatment.
Please feel free to ask receptionist for help in completing this form.

LAST NAME	FIRST	INITIAL	DATE OF BIRTH D M Y
ADDRESS			
CITY/PROVINCE			POSTAL CODE
TELEPHONE RESIDENCE	TELEPHONE BUSINESS	EMAIL	
OCCUPATION	EMPLOYER		
WHOM MAY WE THANK FOR REFERRING YOU?			
PERSON RESPONSIBLE FOR ACCOUNT		DO YOU HAVE DENTAL INSURANCE? ☐ YES ☐ NO	

PRIMARY DENTAL INSURANCE		SECONDARY DENTAL INSURANCE	
NAME OF INSURED	DATE OF BIRTH D M Y	NAME OF INSURED	DATE OF BIRTH D M Y
EMPLOYER		EMPLOYER	
INSURANCE CARRIER		INSURANCE CARRIER	
GROUP/POLICY NUMBER	DIVISION	GROUP/POLICY NUMBER	DIVISION
I. D. NUMBER OF S.I.N		I. D. NUMBER OF S.I.N	
CERTIFICATE NUMBER		CERTIFICATE NUMBER	

HEALTH QUESTIONNAIRE To help ensure your well being while receiving treatment in our office, please answer the following questions.
All information will be considered confidential and for our records only.

Please check box

1. Have you been examined and/or treated by a physician within the last year?________ ☐ Yes ☐ No

   Physician's Name ________ Physician's Phone ________

2. Have you ever been seriously ill or hospitalized? ________ ☐ Yes ☐ No
3. Have you ever experienced abnormal bleeding associated with previous extraction, surgery or trauma? ________ ☐ Yes ☐ No
4. Are you taking any medications or non-prescription drugs now?________ ☐ Yes ☐ No

   What? ________

5. Do you have any allergies? What? ________ ☐ Yes ☐ No
6. Have you ever been told that you require antibiotics before dental treatment? ________ ☐ Yes ☐ No

Please check (.,l) if you have or have had any of the following?

- ☐ Rheumatic fever - yr.________
- ☐ Heart murmur
- ☐ Congenital heart condition
- ☐ Heart attack - yr.______
- ☐ Stroke - yr.________
- ☐ Angina
- ☐ Blood pressure problems
- ☐ Heart trouble
- ☐ Hepatitis/jaundice - hepatitis a. b, c
- ☐ Liver disease
- ☐ Diabetes
- ☐ Blood disorders
- ☐ Pacemaker/artificial valves - yr.________
- ☐ Artificial joints/implants - yr.________
- ☐ Infectious/communicable disease
- ☐ Positive testing for HIV virus
- ☐ AIDS
- ☐ Nervous/Mental problems
- ☐ Epilepsy
- ☐ Thyroid disease - yr.________
- ☐ Arthritis
- ☐ Inflammatory rheumatism
- ☐ Cortisone/steroid therapy - yr.______
- ☐ Unusual reaction to any drug
- ☐ Bruise easily
- ☐ Severe headaches
- ☐ Sinus trouble
- ☐ Sore throats
- ☐ Earaches
- ☐ Trouble hearing
- ☐ History of family disease - what?________

WOMEN ONLY:
Are you Pregnant how many months ________

Is there anything else concerning your health that you think the doctor should know about? ☐ Yes ☐ No

____
Patient (parent/guardian)

DENTAL HISTORY

1. Reason for today's visit: ☐ Exam ☐ Cleaning ☐ Emergency ☐ Other ____________

   Is there a dental problem you would like to have taken care of as soon as possible? ____________

2. How frequently do you see your dentist? ☐ 6 Months ☐ Yearly ☐ Other ____________

   Former dentist ____________ Last dental visit ____________

   Last cleaning ____________ Last full mouth series of x-rays ____________

3. Have you been given oral hygiene instruction in: ☐ Brushing ☐ Flossing ☐ Other ____________ By whom? ____________
4. Are any of your teeth sensitive to: ☐ Cold ☐ Sweets ☐ Heat ☐ Other ____________
5. Do your gums bleed when: ☐ Brushing ☐ Flossing ☐ Spontaneously
6. Is your sugar intake: ☐ High ☐ Medium ☐ Low
7. Have you ever had or do you now have any of the following: Please check

☐ Bridges	☐ Lost filling	☐ Bite appliance/night guard	☐ Difficulty opening or closing your jaw
☐ Partial dentures	☐ Extractions	☐ Injuries to your face or jaws	
☐ Full dentures	☐ Loose teeth	☐ Surgery in your mouth	
☐ Root canal fillings	☐ Orthodontic treatment	☐ Gum treatments	
☐ Dental implants	☐ Bite adjustment	☐ Gag easily	

	Please check box	
8. Does any part of your mouth hurt when clenched? ____________	☐ Yes	☐ No
9. Does your jaw crack or pop when opened widely? ____________	☐ Yes	☐ No
10. Do you have any pain in your ears? ____________	☐ Yes	☐ No
11. Have you experienced any growth or sore spots in your mouth? If so, where? ____________	☐ Yes	☐ No
12. Do you grind or clench your teeth during the day or night? ____________	☐ Yes	☐ No

13. Do you smoke? ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Other ____________
14. Check any of the following you are interested in or you have thought about:

☐ Orthodontics {braces)	☐ Repairing chipped teeth	☐ Improved gum health
☐ Bonding {straightening)	☐ Bleaching {whitening teeth)	☐ Improving your bite
☐ Closing spaces between teeth	☐ Crowns {caps)	☐ Sports mouth guard
☐ Replacing missing teeth	☐ Improved breath odor	☐ Improving your smile

15. Would you rate your current dental health as: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
16. Do you have any emotional concerns regarding your dental visit? ☐ Fear ☐ Pain ☐ Time ☐ Money ☐ Embarrassment

    Other concerns ____________

MEDICAL HISTORY UPDATE *(For office use only}*

Date	Same	Change	Patient Signature	Dr. Initials	Date	Same	Change	Patient Signature	Dr. Initials
________	☐	☐	____________	________	________	☐	☐	____________	________
________	☐	☐	____________	________	________	☐	☐	____________	________
________	☐	☐	____________	________	________	☐	☐	____________	________
________	☐	☐	____________	________	________	☐	☐	____________	________

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