HEALTH/ INSURANCE QUESTIONNAIRE

The information request below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided will be kept in strict confidence unless allowed or required by law. Your written permission will be required to release any information.

DATE_____ SURNAME_____ GIVEN NAME_____

Date of birth: Mo._____ Day____ Yr._____ Sex: F/ M Primary#:_____Cell/Work: _____

Address: _____ City: _____ Postal Code: _____

Email Address: _____ Confirm your appointments via email: Yes/ No

Emergency contact (name) _____ Number: _____ Relationship: _____

Dental insurance? Yes/ No Insurance Company_____ Employer_____

Policy #_____Division_____ Subscribers I.D #_____

Cardholders name: _____ Date of birth: _____

If you were referred to our office, whom may we thank_____ Last dental exam_____

Have you ever been referred for general anesthesia, intravenous or nitrous oxide sedation? Yes/No

Are you nervous or anxious during dental treatment? Yes/ No

Please check off if you have any of the following concerns:

___ Toothache ___ Extraction required ___Sore gums ___ Implants ___ Dentures ___ Wisdom teeth
___Crown/bridge work ___Regular check up ___Dental cleaning ___broken filling/tooth

Medical History

Health Card #: _____ Physician_____ Height_____ Weight_____

1) Are you presently being treated by a physician? Yes/No **2)** Last medical exam_____

3) Are you taking any prescribed medications, non-prescription drugs or herbal supplements of any kind? Yes/ No
If yes, name, dose and frequency _____

4) Do you smoke or chew tobacco? Yes/No **5)** Do you drink alcohol? Yes/No **6**) Recreational Drugs_____

7) If female, are you pregnant? Yes/ No **8)** Do you snore or have been told you stop breathing while asleep? Yes/No

9) Have you ever been hospitalized? Yes/No If yes why? _____

10) Do you have a prosthetic heart valve? Yes/No **11)** Do you have a pacemaker? Yes/No

12) Any previous surgery? Yes/ No If yes what? _____

13) Have you ever had radiation treatment to your head or neck? Yes/No

14) Is there any condition that we should be aware of that would assist us with your treatment? _____

15) Have you ever had or been treated for the following?

___ Liver disorder	___Kidney disorder	___Heart attack	___ Diabetes	___Acid Reflux
___ Endocarditis	___ High blood pressure	___ Seizure Disorder	___ Breathing Problems	___Osteoporosis
___ Anemia	___ Stroke	___ Angina	___ Cancer	___Thyroid problems
___ Hepatitis	___ Artificial joints	___Bleeding problems		

16) Are you allergic to any of the following?

___ Penicillin	___Latex	___Steroids	___ Barbiturates	___ Local Anesthetics
___ Tetracycline	___ Aspirin	___ Erythromycin	___ Codeine	___ Valium/Benzodiazepines
___ Metals	___ Foods	___ Other _____		

The information I have given above is true and to the best of my knowledge. _____

Patient or Guardian Signature