DR. JOE DENTISTRY

HEALTH QUESTIONNAIRE

General Information

Date: ___ / ___ /_____

Primary purpose of visit:

☐ Changing Dentists ☐ Cleaning ☐ Long overdue for dental visit
☐ Pain ☐ Cosmetic (Veneers / Braces / Implants) ☐ Other: _____

Which of the following qualities are most important to you during your dental visit?

☐ Honesty ☐ Friendly Staff ☐ New & Modern Technology
☐ Gentle Dentistry ☐ Budget / Finances ☐ Other: _____

What is the level of your dental anxiety or nervousness?

☐ Mild ☐ Moderate ☐ Severe ☐ Extremely severe!

Name: _____ _____ _____ ☐ Male ☐ Female
Last First Middle Initial

Address: _____ _____
Street Apt/Unit

_____ _____ _____
City State Zip

Birthdate: ___ / ___ / _____ Social Security: _____-_____-_____
Cell Phone: (_____)_____-_____ Home Phone: (_____)_____-_____
Email: _____ @ _____
Employer: _____ Occupation: _____

Dental Insurance

Person responsible for account: _____ Subscriber's name: _____
Relationship to patient: _____ Birthdate: ___ / ___ / _____
Insurance company: _____ ID #: _____ Group #: _____

Health Insurance

Person responsible for account: _____ Subscriber's name: _____
Relationship to patient: _____ Birthdate: ___ / ___ / _____
Insurance company: _____ ID #: _____ Group #: _____

Family Physician:

Name: _____ Phone: (_____)_____-_____

Dental Health

Y N

- ☐ ☐ Pain or discomfort at this time?
- ☐ ☐ Clench or grind your teeth?
- ☐ ☐ Teeth sensitive to hot or cold?
- ☐ ☐ Sensitive or bleeding gums?
- ☐ ☐ Any type of trauma to your mouth, jaw or face? If yes, describe:

  _____
- ☐ ☐ Would you like to change anything about your smile? If yes, describe:

  _____
- ☐ ☐ Asked by your medical doctor to pre-medicate before any dental treatment?
- ☐ ☐ Taken Fen-Phen, Redux or appetite suppressants? If yes, have you seen a physician for a cardiac evaluation? _____

Medical Health

Have you been hospitalized in the last five (5) years? Yes ☐ No ☐ If yes, please describe: _____

_____

Are you allergic or have you reacted adversely to any of the following (check all that apply):

Y N

- ☐ ☐ Penicillin
- ☐ ☐ Metal: _____
- ☐ ☐ Nitrous oxide
- ☐ ☐ Antibiotics: _____

Y N

- ☐ ☐ Latex
- ☐ ☐ Ibuprofen
- ☐ ☐ Acetaminophen / Tylenol
- ☐ ☐ Local anesthesia (Novocaine)

Please list any other allergies to include medications you are allergic to:

_____

_____

_____

Check any of the following that you have had or have at the present:

Y N

- ☐ ☐ High blood pressure
- ☐ ☐ Heart disease or heart surgery
- ☐ ☐ Artificial joints / Heart valves (Circle One)
- ☐ ☐ Psychological disorder
- ☐ ☐ History of drug addiction / alchoholism
- ☐ ☐ Radiation treatment
- ☐ ☐ Hepatitis A / Hepatitis B (Circle One)

Y N

- ☐ ☐ Diabetes Type 1 / Diabetes Type 2 (Circle One)
- ☐ ☐ Asthma / breathing disorder
- ☐ ☐ Bleeding disorder
- ☐ ☐ Tuberculosis or lung disease
- ☐ ☐ AIDS or HIV+
- ☐ ☐ Bisphosphonate therapy (for Osteoporosis)

Y N

- ☐ ☐ Do you have any disease, condition or problem not listed?

_____

_____

Major surgeries:

Year: _____ Description: _____

Year: _____ Description: _____

Year: _____ Description: _____

Year: _____ Description: _____

Please list all medications you are currently taking (including prescription and OTC) (Example listed below.)

Name of medication	Dosage in mg.	Number of times taken	When (daily, as needed)
i.e. Aleve	275	2x	daily

For Women Only

Y	N	
☐	☐	Are you pregnant? If yes, due date: _____
☐	☐	Are you taking birth control pills?
☐	☐	Could you be pregnant?
☐	☐	Are you nursing?
☐	☐	Hormone replacement?

Emergency

Name: _____ Relationship: _____

Phone: _____

Authorization

I have reviewed the information on this form and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status I will inform the dentist.

Name (Print): _____

Signed: _____

Date: _____

For Staff Use:

[Reviewed by] Initials / Date: _____