Medical and Dental
History Questionnaire

Welcome! So that we may provide you with the best possible care, please complete both sides of this Medical/dental history form. All information is completely confidential.

Date___________________

Name____Address_______________________________Home Phone (   ) __________

City/Town____________________________State__________Zip Code______________Cell Phone (_____)_____________________

Date of Birth______________Occupation______________________EMAIL: ____

Employer's Name______________________Employer's Address_______________________Social Security#___________________

Patient's Status: Child ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐

Spouse's Name________________________Spouse's Address____

Dental Insurance Coverage Yes ☐ No ☐ Name of Insurance Co.____

Agreement/I.D. Number_________________Group Number_________Insured Social Security #______________________________

Person Responsible for Account_________________________Relationship____________Insured Date of Birth__________________

Whom may we thank for referring you?____

Name and phone number of Physician ____

Name and phone number of person to contact in case of emergency (someone who does not live at your address)

____

	Yes	No
Have you been a patient in a hospital in the past 2 years?	Yes ☐	No ☐
Have you been under the care of a Doctor during the past 2 years?	Yes ☐	No ☐
Are you allergic to any medication or substance? (Penicillin, codeine, ________________________)	Yes ☐	No ☐
Have you ever had an excessive bleeding requiring special treatment?	Yes ☐	No ☐
(Women) Are you pregnant?	Yes ☐	No ☐
Are you taking birth control pills?	Yes ☐	No ☐
Is there any history of diabetes or heart disease in your family?	Yes ☐	No ☐

Indicate any of the following, which you have had, or have at present. Check all that apply.

- ☐ Heart (Surgery, Disease, Attack)
- ☐ Chest pain
- ☐ Congenital Heart Disease
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Artificial Heart Valve
- ☐ Heart Pacemaker
- ☐ Rheumatic Fever
- ☐ Arthritis/Rheumatism
- ☐ Cortisone Medicine
- ☐ Swollen Ankles
- ☐ Stroke
- ☐ Diet (Special/Restricted)
- ☐ Artificial Joints (hips, knees, etc)
- ☐ Kidney Trouble
- ☐ Ulcers
- ☐ Thyroid Problems
- ☐ Hepatitis A (infectious) B (serum) C
- ☐ Glaucoma
- ☐ Contact Lenses
- ☐ Emphysema
- ☐ Chronic Cough
- ☐ Tuberculosis
- ☐ Asthma
- ☐ Diagnosed Metal Allergy
- ☐ Latex Sensitivity
- ☐ Allergies or Hives
- ☐ Sinus Trouble
- ☐ Radiation Therapy
- ☐ Chemotherapy
- ☐ Tumors/Growths
- ☐ Diabetes Type 1__ Type 2__
- ☐ A.I.D.S
- ☐ Venereal Disease
- ☐ H.I.V. Positive
- ☐ Cold Sores/Fever Blisters
- ☐ Blood Transfusion
- ☐ Hemophilia
- ☐ Sickle Cell Disease
- ☐ Bruise Easily
- ☐ Liver Disease
- ☐ Yellow Jaundice
- ☐ Neurological Disorders
- ☐ Epilepsy or Seizures
- ☐ Fainting or Dizzy Spells
- ☐ Nervous/Anxious
- ☐ Psychiatric Treatment

Have you taken any kind of medicine or drugs in the past year?___________
Have you taken any over the counter medications or herbal products? __________
Please list all medications and/or over counter products on the attached medication form or submit a copy.

Do you use marijuana? Yes or No, Do you have a medical marijuana card? Yes or No

Do you want paper billing statement? Yes or No

Do you want an email statement? Yes or No, If Yes then what EMAIL_______________________________________

Do you have specific days you prefer? ____

Do you have specific time of day you prefer? ____

What is the reason for your visit today?____
Date of last Dental visit_____________________Last Dental Cleaning_____________________________________

Are any of your teeth sensitive to:

Hot or Cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No

Have you ever noticed:

Mouth odors or bad tastes?	Yes	No
Cold sores, blisters, or oral lesions?	Yes	No
Loose teeth or change in bite?	Yes	No
Food caught in between your teeth?	Yes	No

Do you:

Clench or grind your teeth?	Yes	No
Have bleeding gingival tissues (gums)?	Yes	No
Or have you experienced pain/discomfort in your jaw (TMJ)?	Yes	No
Have pain or clicking in joint just in front of ear?	Yes	No
Smoke, chew tobacco, vape, or use marijuana (recreational or medicinal)? Circle all that apply	Yes	No

Are you satisfied with your teeth's appearance?	Yes	No
Would you like to keep your teeth all your life?	Yes	No
Would you like to be shown how to maintain your teeth?	Yes	No
Would you like to prevent partials/dentures?	Yes	No
Do you experience anxiety when you visit a dental office?	Yes	No

I hereby give consent for treatment and the use of such local anesthetic or the taking of any Radiographs, which may be deemed advisable by the Doctor. I hereby understand that payment is due at time of services are rendered and that I am responsible for all balances including late fees, broken appointments fees, collection fees, emergency fees, administrative fees, and/or unpaid balances or copayments by the insurance company.
I hereby acknowledge that all information I have provided is to best of my ability and can/ will be used for the treatment, payment, and health care operations.
Signature of Patient, Parent, or Legal Guardian____Date_______
Thank you for your cooperation in filling out this questionnaire. It will enable us to attend to your dental needs in the most efficient, comfortable, and safe manner possible.