Dental Questionnaire

Form 401D

Today's Date: _____ Patient # _____

PATIENT INFORMATION

☐ Mr. ☐ Ms ☐ Miss ☐ Mrs. ☐ Dr.

Name: _____

Address _____

City/State/Zip _____

How long at current address? _____

Phone# _____ SS # _____

Cell Phone _____

Email _____

Birth Date _____ Age _____ ☐ Male ☐ Female

☐ Single ☐ Married ☐ Widowed
☐ Separated ☐ Divorced ☐ Dependent

RESPONSIBLE PARTY

IF OTHER THAN PATIENT

Relationship to patient _____

Name: _____

Address _____

City/State/Zip _____

How long at current address? _____

Phone# _____ SS #_____

Birth Date _____ Age _____ ☐ Male ☐ Female

☐ Single ☐ Married ☐ Widowed
☐ Separated ☐ Divorced

EMPLOYMENT INFORMATION

Employer _____

Work Phone _____

Occupation _____

How Long at Current Job? _____

INSURANCE

Insurance Company _____

Address _____

City/State/Zip _____

Phone # _____

Insured's Employer _____

Insured's Name _____

Relationship to Patient _____

Insured's SS # or Membership # _____

POLICY / GROUP NUMBER _____

PLEASE CHECK ALL DENTAL CONCERNS THAT APPLY TO YOU:

TEETH:

☐ Broken or Chipped
☐ Crooked
☐ Decay
☐ Difficulty Chewing
☐ Discolored
☐ Food Trap Areas
☐ Grinding or Clenching
☐ Loose or Missing Filling
☐ Loose Tooth or Teeth
☐ Missing Tooth or Teeth
☐ Mouth Sores
☐ Sensitive to Temperature Changes
☐ Sensitive to Sweets
☐ Tooth Pain

GUMS:

☐ Bleeding
☐ Pimple or Bump
☐ Sore or Sensitive

JAW / FACIAL PAIN PROBLEMS

☐ Facial Pain
☐ Frequent Headaches
☐ Jaw Clicks
☐ Jaw Pain
☐ Pain in Cheeks or Temples

OTHER CONCERNS OR REASONS FOR VISIT:

_____

_____

☐ Here for a Periodic Examination. No specific Known Dental Problems.

PAST DENTAL HISTORY:

Last Dental Visit _____

Dental Visit Frequency Ever:

_____ Months _____ Years _____ As Needed

Have Tooth Replacements such as Dentures, Partials, Bridges or Implants?

☐ Satisfied ☐ Dissatisfied

Other: _____

Patient Signature _____

LIST ANY MEDICATIONS WHICH HAVE CAUSED AN ALLERGIC REACTION:

Y ☐ N ☐ Antibiotics
Y ☐ N ☐ Aspirin
Y ☐ N ☐ Codeine
Y ☐ N ☐ Iodine
Y ☐ N ☐ Latex
Y ☐ N ☐ Local anesthetics
Y ☐ N ☐ Metals
Y ☐ N ☐ Novocaine
Y ☐ N ☐ Penicillin
Y ☐ N ☐ Plastic
Y ☐ N ☐ Sedatives
Y ☐ N ☐ Sleeping pills
Y ☐ N ☐ Sulfa drugs

Other allergens: _____

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

Y ☐ N ☐ Antibiotics
Y ☐ N ☐ Anticoagulants
Y ☐ N ☐ Blood Thinners
Y ☐ N ☐ Blood Pressure
Y ☐ N ☐ Codeine
Y ☐ N ☐ Cortisone
Y ☐ N ☐ Diet pills
Y ☐ N ☐ Digestive Aids
Y ☐ N ☐ Heart medication
Y ☐ N ☐ Insulin
Y ☐ N ☐ Muscle relaxants
Y ☐ N ☐ Pain Medication
Y ☐ N ☐ Sleeping Pills
Y ☐ N ☐ Tranquilizers

Other current medications: _____

MEDICAL HISTORY

Y ☐ N ☐ Anemia
Y ☐ N ☐ Arthritis
Y ☐ N ☐ Artificial Joint or Prosthetic
Y ☐ N ☐ Asthma
Y ☐ N ☐ Bleeding Easily After a Cut
Y ☐ N ☐ Cancer
Y ☐ N ☐ Chronic Mouth Dryness
Y ☐ N ☐ Current Pregnancy
Y ☐ N ☐ Depression
Y ☐ N ☐ Diabetes
Y ☐ N ☐ Digestive Problems
Y ☐ N ☐ Dizziness
Y ☐ N ☐ Epilepsy or Seizure
Y ☐ N ☐ Headaches
Y ☐ N ☐ Heart Murmur
Y ☐ N ☐ Heart Pacemaker
Y ☐ N ☐ Heart Palpitations
Y ☐ N ☐ Heart Valve Replacement
Y ☐ N ☐ Heart Valves Damaged
Y ☐ N ☐ Hepatitis
Y ☐ N ☐ High Blood Pressure
Y ☐ N ☐ Immune System Disorder
Y ☐ N ☐ Injury to
☐ Face ☐ Mouth
☐ Neck ☐ Teeth
Y ☐ N ☐ Kidney Problems
Y ☐ N ☐ Liver Problems
Y ☐ N ☐ Low Blood Pressure
Y ☐ N ☐ Osteoporosis
Y ☐ N ☐ Radiation Treatment
Y ☐ N ☐ Respiratory Problems
Y ☐ N ☐ Rheumaic Fever
Y ☐ N ☐ Scarlet fever
Y ☐ N ☐ Sinus problems
Y ☐ N ☐ Tuberculosis

Other medical history:
_____
_____

DESCRIBE ANY SERIOUS ILLNESS, MAJOR SURGERY OR CONDITIONS NOT LISTED ABOVE:

Date	Description
_____	_____
_____	_____
_____	_____

ARE YOU UNDER A PHYSICIAN'S CARE?

Practitioner	Specialty	Treatment & Approximate Date
_____		
_____		

Primary Care Physician _____

IF VISIT IS DUE TO ACCIDENT, PLEASE DESCRIBE:

_____

I authorize the release of a full report of examination findings, diagnosis, treatment program, etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation. I understand that I am responsible for all fees for treatment regardless of insurance coverage.

Patient Signature _____ _____