

Get acquainted and medical history questionnaire (CONFIDENTIAL)

Thank you for choosing our office to serve you. In order to serve you better, please fill in the following information completely. We have asked only questions that we feel are necessary to protect you medically and to safeguard our staff. Please complete both sides.

Name _____ S.S# _____

Date of Birth: _____ Phone(Hm) _____ Work _____ Cell _____

Address: _____

City: _____ State _____ Zip _____

Children: Name and Age _____

Person responsible for Payment _____ Their S.S# _____

Patient's Employer _____ Occupation _____ Shift _____

Employer's Address _____

Spouse's Name _____ Their S.S# _____

Spouse's Employer _____ Occupation _____ Shift _____

Spouse's Employer Address _____

Whom may we thank for referring you to our office? _____

DENTAL HISTORY

Purpose of this visit and present problem _____

Last dental visit _____ Last cleaning _____

When was your last full dental x-rays taken? _____

Do you like your smile? Yes ___ No ___ How often do you floss _____

How often do you brush? _____ Type of Brush used? Soft ___ Hard ___

Do you use a power tooth brush? What brand? _____

Have you ever been instructed how to brush? Yes ___ No ___ How to floss? Yes ___ No ___

Are there any growths, sore spots, or unhealed areas in your mouth? Yes ___ No ___

Have you had any difficult extractions in the past? Yes ___ No ___

Have you ever had ortho treatment? Yes ___ No ___

Do you smoke or chew tobacco? Yes ___ No ___

Are any of your teeth currently sensitive to heat or cold? Yes ___ No ___

Does food catch between your teeth? Yes ___ No ___

Have you ever had any periodontal (gum)treatment? Yes ___ No ___

Have you any objections to the use of local anesthetic (Novocain)? Yes ___ No ___

Yes ___ No ___ Pain in or near your ear

Yes ___ No ___ Partial/dentures

Yes ___ No ___ Bad Breath

Yes ___ No ___ Cold or canker sores

Yes ___ No ___ Dry Sockets

Yes ___ No ___ Bleeding gums

Yes ___ No ___ Clench or grind teeth

Yes ___ No ___ Jaw Clicking

Yes ___ No ___ Pain when opening your jaw

Yes ___ No ___ Do you snore

MEDICAL HISTORY

Physician's name and address _____

Date of last physical exam _____ Are you under medical care now? Yes ___ No ___

Have you been in the hospital in the past 5 years? Yes ___ No ___ For what? _____

Are you taking any medicine? Yes ___ No ___ For What? _____

What medicines? _____

Are you taking Fosamax, Boniva or any other Bisphosphonates? Yes ___ No ___

Are you allergic to any medications? Yes ___ No ___ What are they? _____

Are you allergic to any metals? Yes ___ No ___ What type? _____

Are you on a special diet? Yes ___ No ___ Are you pregnant? Yes ___ No ___ If yes, due date is _____

Are you in good health? Yes ___ No ___ Do you use an inhaler? Yes ___ No ___

Do you have any of the following?

Yes ___ No ___ Blood Disease/Anemia Yes ___ No ___ Diabetes Yes ___ No ___ Stomach, Intestinal Disease

Yes ___ No ___ Rheumatism/Arthritis Yes ___ No ___ Cancer Yes ___ No ___ Stroke

Yes ___ No ___ Hepatitis/Liver Disease Yes ___ No ___ Radiation Treatment Yes ___ No ___ Aids

Yes ___ No ___ Epilepsy/Seizures Yes ___ No ___ Thyroid Conditions Yes ___ No ___ Head or Jaw Injury

Yes ___ No ___ Cognitive Disabilities Yes ___ No ___ High Blood Pressure Yes ___ No ___ Kidney disease/Jaundice

Yes ___ No ___ Mental Health Conditions Yes ___ No ___ Pacemaker Yes ___ No ___ Birth Control

Yes ___ No ___ Prolonged Bleeding Yes ___ No ___ Blood Transfusions Yes ___ No ___ Heart Trouble

Yes ___ No ___ Drug/Alcohol Abuse Yes ___ No ___ Tumors/Growths Yes ___ No ___ Other Serious Illnesses

Yes ___ No ___ Difficulty with sight Yes ___ No ___ Hard of Hearing Yes ___ No ___ Artificial Joints

Yes ___ No ___ Fainting/Nervousness

Yes ___ No ___ Premedication (For what?) _____

COMMENTS or CONCERNS:

Signature: _____ **Date:** _____