Downtown Dental Medical and Dental History Questionnaire

_____ _____ _____ _____
FULL NAME DOB M/F DATE

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

IT IS IMPORTANT THAT WE KNOW ABOUT YOUR MEDICAL AND DENTAL HISTORY. THESE FACTS HAVE A DIRECT BEARING ON YOUR DENTAL HEALTH. INFORMATION IS STRICTLY CONFIDENTIAL AND WILL NOT BE RELEASED TO ANYONE. THANK YOU FOR TAKING THE TIME TO COMPLETE THE FOLLOWING INFORMATION.

DENTAL HISTORY

HOW LONG HAS IT BEEN SINCE YOU HAVE SEEN A DENTIST? _____

DATE OF LAST COMPLETE DENTAL EXAM? _____

WHAT IS THE REASON FOR TODAY'S VISIT? _____

ARE YOU HAPPY WITH YOUR SMILE? _____ HAVE YOU EVER BEEN TREATED FOR GUM DISEASE? _____

ARE YOUR TEETH SENSITIVE TO SWEETS? _____ COLD? _____ HEAT? _____ PRESSURE? _____

HAVE YOU EXPERIENCED PAIN OR SORENESS IN THE MUSCLES OF YOUR FACE? _____

DO YOU CLENCH OR GRIND YOUR TEETH? _____

ARE YOU CONCERNED WITH THE APPEARANCE OF YOUR TEETH? _____ WOULD YOU LIKE WHITER TEETH? _____

ARE YOU APPREHENSIVE OR NERVOUS ABOUT DENTAL TREATMENT? _____

HOW DO YOU FEEL ABOUT YOUR TEETH? _____

MEDICAL HISTORY

HAVE YOU BEEN HOSPITALIZED WITH A SERIOUS ILLNESS IN THE PAST 3 YEARS? _____

DO YOU HAVE ANY CURRENT HEALTH PROBLEMS? _____

ARE YOU UNDER THE CARE OF A PHYSICIAN? _____ WHAT FOR? _____

DATE OF LAST MEDICAL EXAM? _____ FAMILY PHYSICIAN: _____ PH #: _____

HAVE YOU HAD OR DO YOU HAVE ANY OF THESE CONDITIONS?			PLEASE EXPLAIN BELOW
☐ CHEST PAIN ☐ SWOLLEN ANKLES ☐ SHORTNESS OF BREATH ☐ RECENT WEIGHT LOSS ☐ PERSISTENT COUGH ☐ BLEEDING PROBLEMS ☐ SINUS PROBLEMS ☐ JOINT PAIN, STIFFNESS ☐ DIFFICULTY SWALLOWING ☐ HEADACHES ☐ RINGING IN EARS ☐ FAINTING SPELLS	☐ SEIZURES ☐ EXCESSIVE THIRST ☐ DRY MOUTH ☐ JAUNDICE ☐ THYROID DISEASE ☐ HIGH BLOOD PRESSURE ☐ HEART MURMURS ☐ RHEUMATIC FEVER ☐ HEART DISEASE ☐ DIABETES ☐ ASTHMA ☐ HEART ATTACK	☐ STROKE ☐ ALLERGIES: _____ ☐ LIVER DISEASE ☐ HEPATITIS ☐ STOMACH ULCERS ☐ HIV/AIDS ☐ ARTHRITIS ☐ ANEMIA ☐ HERPES ☐ CANCER ☐ OTHER	

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DO YOU HAVE OR HAVE YOU HAD?	ARE YOU TAKING OR HAVE YOU TAKEN?	PLEASE EXPLAIN
☐ PSYCHIATRIC CARE ☐ PROSTHETIC HEART VALVE ☐ BLOOD TRANSFUSION ☐ RADIATION TREATMENTS ☐ ARTIFICIAL JOINT ☐ SURGERIES ☐ CHEMOTHERAPY ☐ HOSPITALIZATION ☐ PACEMAKER	☐ ALCOHOL ☐ DIET PILLS ☐ RECREATIONAL DRUGS ☐ BISPHOSPHONATE (FOSAMAX, BONIVA) ☐ TOBACCO (ANY FORM) ☐ MEDICATIONS	

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING

HAVE YOU EVER HAD TO BE PRE-MEDICATED FOR A DENTAL APPOINTMENT? _____

DO YOU SMOKE? _____ FOR HOW LONG? _____ HOW MANY/DAY? _____

ARE YOU PREGNANT OR TRYING TO GET PREGNANT? _____

IS THERE ANY MEDICAL OR DENTAL INFORMATION THAT HAS NOT BEEN COVERED ON THIS FORM THAT WE SHOULD KNOW

ABOUT? _____

FINANCIAL POLICY

PAYMENT IS DUE WHEN SERVICE IS RENDERED. WE ACCEPT MOST MAJOR INSURANCE PLANS AND WILL DO OUR BEST TO ESTIMATE HOW MUCH YOUR INSURANCE COMPANY WILL PAY TOWARDS SERVICES. HOWEVER, ANY PORTION NOT PAID BY THE INSURANCE COMPANY IS YOUR RESPONSIBILITY. WE ACCEPT CASH, PERSONAL CHECKS, AND ALL MAJOR CREDIT CARDS. WE REALIZE THAT SOME PROCEDURES ARE MORE EXTENSIVE THAN OTHERS AND WE WILL BE MORE THAN WILLING TO WORK OUT ALTERNATIVE FINANCIAL ARRANGEMENTS PRIOR TO TREATMENT. I UNDERSTAND AND AGREE THAT, REGARDLESS OF MY INSURANCE OR MARTIAL STATUS, I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE ON THIS ACCOUNT FOR ANY SERVICES RENDERED.

TO THE BEST OF MY KNOWLEDGE, THE DENTAL & MEDICAL HISTORY QUESTIONNAIRE IS COMPLETE AND ACCURATE. I HAVE ALSO READ THE FINANCIAL POLICY AND UNDERSTAND MY FINANCIAL OBLIGATIONS. PLEASE SIGN
SIGNATURE: Date:_____