



CLIENT INFORMATION

Adult Child Guardian Name _____ Male Female

Taken by _____ Date _____

Name _____ Date of Birth _____

Telephone: (H) _____ (W) _____ (Cell) _____

E-mail _____

Address _____ Apt/Unit _____ City _____ Postal Code _____

Last Dental/Hygiene visit? _____ Dentist's Name _____

Do you have any allergies? _____

Do you require PreMed for your dental visits? _____

Referred By _____ Treatment _____

Insurance Info: Policy # _____ ID # _____ Carrier _____

Person Responsible for Account _____ Relationship _____

Employer _____

Payment Discussed: MasterCard _____ VISA _____ Amex _____ Debit _____ Cash _____

Best Time for Appointments: Morning _____ Noon _____ Evenings _____ Anytime _____

In Case of an Emergency whom should we contact? _____

Appointment Booked

Provider _____ Appointment Date _____ Time _____

**ACCOUNTS ARE DUE WHEN SERVICES ARE RENDERED OR REASONABLE FINANCIAL
ARRANGEMENTS ARE AVAILABLE**



MEDICAL HISTORY QUESTIONNAIRE

MEDICAL ALERT:

NAME: MR./MISS/MRS./MS./DR.

DATE OF BIRTH (DAY/MONTH/YEAR):

ADDRESS (HOME):

PHONE: CELL:

NAME OF EMPLOYER:

EMAIL ADDRESS:

PHONE:

OCCUPATION:

WHO REFERRED YOU TO OUR OFFICE?

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

NAME:

RELATIONSHIP:

DAY-TIME PHONE:

NAME OF FAMILY DOCTOR:

PHONE OR ADDRESS:

(1) NAME OF MEDICAL SPECIALIST:

AREA OF SPECIALTY:

PHONE OR ADDRESS:

(2) NAME OF MEDICAL SPECIALIST

AREA OF SPECIALTY:

PHONE OR ADDRESS:

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dental hygienist will review the questions and explain any that you do not understand. Please fill in the entire form.

1. Are you being treated for any medical condition at the present or have you been treated within the past 2 years? If so, why?
Yes No Not Sure / Maybe

2. When was your last medical checkup?

3. Has there been any change in your general health in the past year? If yes, please explain.
Yes No Not Sure / Maybe

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list.
Yes No Not Sure / Maybe

5. Do you have any allergies? If you answered yes, please list using the categories below:
Yes No Not Sure / Maybe

- a) Medications
b) Latex/rubber products
c) Other e.g. hayfever, foods

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.
Yes No Not Sure / Maybe

7. Do you have or have you ever had asthma? Yes No Not Sure / Maybe
-
8. Do you have or have you ever had any heart or blood pressure problems? Yes No Not Sure / Maybe
-
9. Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever? Yes No Not Sure / Maybe
-
10. Do you have a prosthetic or artificial joint? Yes No Not Sure / Maybe
-
11. Have you ever been advised by your doctor to take antibiotics before dental treatment due to a heart condition or artificial joint? Yes No Not Sure / Maybe
-
12. Do you have any conditions or therapies that could effect your immune system e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy, lupus? Yes No Not Sure / Maybe
-
13. Have you ever had hepatitis, jaundice or liver disease? Yes No Not Sure / Maybe
-
14. Do you have a bleeding problem or bleeding disorder? Yes No Not Sure / Maybe
-
15. Have you ever been hospitalized for any illnesses or operations
If yes, please explain. Yes No Not Sure / Maybe
-
16. Do you have or have you ever had any of the following? Please check.
- | | | | | |
|---|---|---------------------------------------|--|--|
| <input type="checkbox"/> chest pain, angina | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> pacemaker | <input type="checkbox"/> steroid therapy | <input type="checkbox"/> seizures (epilepsy) |
| <input type="checkbox"/> heart attack | <input type="checkbox"/> prosthetic heart valve | <input type="checkbox"/> lung disease | <input type="checkbox"/> diabetes | <input type="checkbox"/> kidney disease |
| <input type="checkbox"/> stroke | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> cancer | <input type="checkbox"/> stomach ulcers | <input type="checkbox"/> thyroid disease |
| | | | <input type="checkbox"/> arthritis | <input type="checkbox"/> diet medications |
-
17. Are there any conditions or diseases not listed above that you have or have had? If so, what? Yes No Not Sure / Maybe
-
18. Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease) Yes No Not Sure / Maybe
-
19. Do you smoke or chew tobacco products? Yes No Not Sure / Maybe
-
20. Are you nervous during dental treatment? Yes No Not Sure / Maybe
-
21. Are you taking any non-prescribed drugs or medication? Yes No Not Sure / Maybe
-
22. Are you or have you ever been dependent on alcohol or drugs? Yes No Not Sure / Maybe
-
23. **For women only:** Are you breast-feeding or pregnant? If pregnant, what is the expected delivery date? Yes No Not Sure / Maybe
-

GENERAL RELEASE (Please sign after completing medical questionnaire).

I, the undersigned, certify that I have provided an accurate and complete personal and medical – dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical – dental history. **Should there be any change in either my health status or any other information I have provided, I will advise this dental hygiene office.** I authorize the dental hygienist to perform procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary. I have been advised of the privacy policy of the office and that my personal information will be collected, used and disclosed within the guidelines of the policy. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

(Signature) Patient Parent Guardian

(Print Name of Guardian)

Reviewed by Treating Dental Hygienist: _____ Date: _____



DENTAL HISTORY

Name _____

1. When was your last Dental Hygiene Cleaning? _____ How often did you see your dental hygienist? _____
2. How many times a day do you brush your teeth? _____
3. How often do you floss your teeth? _____
4. How often do you brush your tongue? _____
5. Do you use a mouth rinse? _____ How often? _____ What type? _____

	Yes	No	Not Sure
6. Do your gums bleed when you brush or floss your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you feel you have bad breath?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever had instructions on caring for your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Are there any growths or sore spots in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you ever been diagnosed with periodontal /gum disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever been advised to take antibiotics before dental cleaning?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you ever have a dry or burning mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you breathe from your mouth while you are awake or asleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you ever had an allergic reaction to "freezing" (Local or Topical)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you had prolonged bleeding?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Do you have any present dental problems? (sore gums, sensitivity to hot or cold, bleeding)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If YES, please describe _____

- | | | | |
|---|--------------------------|--------------------------|--------------------------|
| 16. Do you grind or clench your teeth while you're awake or asleep? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|---|--------------------------|--------------------------|--------------------------|

Yes **No** **Not Sure**

17. Do you have pain in your jaw or joint?

18. Have you ever had intra oral photographs taken?

19. Are there any dental or medical concerns not listed or you would like to speak to the Dental Hygienist about in private?

20. Do you have any additional information or comments you would like to add?
