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NEW PATIENT QUESTIONNAIRE

Please Print

Patient Information

Date _____

Patient Mr., Mrs., Dr., Miss _____

Address _____
Street City County State Zip

Employer _____ Occupation _____

Residence Phone _____ Business Phone _____

Marital Status _____ Date of Birth _____

SS# _____ Cell or Pager # _____

Name of Spouse or Parent (if minor) _____

SS# _____ Date of Birth _____

Employer _____ Occupation _____

Business Phone _____

Nearest relative not living at your residence _____

Relationship _____ Phone _____

Name and Phone of Physician _____

Name of General Dentist _____ Number of Years _____

Referred by _____

Dental Insurance Company _____

Employer Providing Insurance _____

Claims Address _____

Name of Policyholder (Employee) _____

Insurance Subscriber # or Social Security # _____

Group No. or Policy No. _____ Relationship to Patient _____

Medical Information

1. Please list any medications you are currently taking and dosages: _____

_____

2. Please list any medication you are allergic to (make you swell, itch, or break out in a rash) _____

3. Have you ever had a bad reaction to local or general anesthesia? Yes No

4. Have you ever taken any steroid or cortisone medicine? Yes No

5. Have you seen a physician in the past year for any medical problems? Yes No

6. Please list any hospital visits in the past 3 years? _____

_____

7. Circle any of the following conditions you have had:

a. heart trouble
b. heart murmur
c. high blood pressure
d. rheumatic or scarlet fever
e. chest pain
f. shortness of breath
g. lung problems
h. asthma
i. emphysema
j. chronic cough
k. pneumonia
l. tuberculosis
m. HIV or AIDS Virus
n. sinus or ear trouble
o. stomach or GI problems: ulcers, colitis, etc
p. liver problems (hepatitis or jaundice)
q. kidney problems
r. diabetes
s. thyroid problems
t. tumors or cancer
u. epilepsy
v. psychological problems
w. radiation treatments for cancer or tumors
x. bleeding after surgery (including dental extractions)

8. Please provide information on above conditions that are circled: _____

_____

_____

_____

9. Women: Are you pregnant? _____

10. Do you require antibiotic premedication prior to dental treatment? Yes No

Dental Information

1. Are you experiencing pain or any problems with your mouth? Yes No
2. Frequency of dental care ___ regular ___ periodic ___ emergency ___
3. Do you know if anyone else in your family has had gum problems? Yes No

   Relationship _____
4. Have you ever had periodontal (gum) treatment? Yes No

If yes, when and by whom? _____

5. Circle any of the following that applies to you:

a. bleeding gums
b. loose teeth
c. sensitive teeth
d. toothache
e. cold sores
f. jaw clicking
g. injury to face or jaw

Explain all that are circled above: _____

_____

6. Do you think your teeth are affecting your health? Yes No
7. Are you satisfied with the appearance of your teeth? Yes No
8. Do you want to save your teeth? Yes No
9. Do you smoke? How many packs a day? _____ Yes No
10. Have you ever had an unpleasant experience in a dental office? Yes No

If so explain _____

SIGNATURE _____
(parent's if patient is under 18)