WELCOME TO OUR OFFICE

ACCOUNT NUMBER

LAST NAME	FIRST	INITIAL	DATE OF BIRTH D M Y
ADDRESS			SEX
CITY/PROVINCE			POSTAL CODE
TELEPHONE RESIDENCE	BUSINESS	MESSAGE	
OCCUPATION	EMPLOYER		
PERSONAL HEALTH #			
PERSON RESPONSIBLE FOR ACCOUNT	SCHOOL	DO YOU HAVE DENTAL INSURANCE? ☐ YES ☐ NO	

PRIMARY DENTAL INSURANCE		SECONDARY DENTAL INSURANCE	
NAME OF INSURED	DATE OF BIRTH D M Y	NAME OF INSURED	DATE OF BIRTH D M Y
EMPLOYER		EMPLOYER	
INSURANCE CARRIER		INSURANCE CARRIER	
GROUP/POLICY NUMBER	DIVISION	GROUP/POLICY NUMBER	DIVISION
I.D. NUMBER OR S.I.N.		I.D. NUMBER OR S.I.N.	
CERTIFICATE NUMBER		CERTIFICATE NUMBER	
COVERAGE PERCENTAGE A B C D		COVERAGE PERCENTAGE A B C D	
LIMITS BASIC MAJOR ORTHO		LIMITS BASIC MAJOR ORTHO	
DEDUCTIBLE BASIC MAJOR	☐ PER PERSON ☐ PER FAMILY	DEDUCTIBLE BASIC MAJOR	☐ PER PERSON ☐ PER FAMILY

MEDIC ALERT

HEALTH QUESTIONNAIRE

To help ensure your well being while receiving treatment in our office, please answer the following questions. All information will be considered confidential and for our records only.

General — Please circle

1. Have you been examined and/or treated by a physician within the last year? _____ Yes No
   Physician's Name_____ Physician's Phone _____
2. Have you ever been seriously ill or hospitalized? _____ Yes No
3. Have you ever experienced abnormal bleeding associated with previous extraction, surgery or trauma? Yes No
4. Are you taking any medications or non-prescription drugs now? _____ Yes No
   What?_____

Please check (✓) if you have or have had any of the following?

SPECIFIC
- ☐ Rheumatic fever
- ☐ Heart murmur
- ☐ Congenital heart condition
- ☐ Heart attack
- ☐ Arteriosclerosis
- ☐ Stroke
- ☐ Angina pectoris
- ☐ Blood pressure problems
- ☐ Heart trouble
- ☐ Lung/breathing problems
- ☐ Kidney/bladder problems
- ☐ Stomach/intestinal problems
- ☐ Hepatitis/jaundice
- ☐ Liver disease
- ☐ Diabetes
- ☐ Blood disorders
- ☐ Pacemaker/artificial valves
- ☐ Artificial joints/implants
- ☐ Infectious/communicable disease
- ☐ Venereal disease
- ☐ AIDS
- ☐ Positive testing for HIV virus
- ☐ Tumors or growths
- ☐ Nervous/Mental problems
- ☐ Epilepsy
- ☐ Thyroid disease
- ☐ Arthritis
- ☐ Inflammatory rheumatism
- ☐ Cortisone/steroid therapy

SENSITIVITIES/ALLERGIES:
- ☐ Hives/skin rash
- ☐ Asthma
- ☐ Hay fever
- ☐ Allergies_____
- ☐ Unusual reaction to any drug

SYSTEMS REVIEW:
- ☐ Prolonged bleeding after injury
- ☐ Bruise easily
- ☐ High risk group for AIDS
- ☐ Severe headaches
- ☐ Sinus trouble
- ☐ Sore throats
- ☐ Earaches
- ☐ Trouble hearing
- ☐ Shortness of breath
- ☐ Chest pains
- ☐ Swollen ankles
- ☐ Heart palpitations
- ☐ Extra pillows for sleep
- ☐ Persistent cough
- ☐ Blood in sputum
- ☐ Recent change of appetite
- ☐ Foods that you cannot eat
- ☐ Difficulty in swallowing
- ☐ Frequent indigestion/vomiting
- ☐ Feel thirsty much of the time
- ☐ Urinate more than 6 times/day
- ☐ Painful, swollen joints
- ☐ Numb/prickling sensations
- ☐ History of broken bones
- ☐ Tendency to faint
- ☐ Fits, seizures or convulsions
- ☐ History of family disease

HABITS:
- ☐ Tobacco
- ☐ Alcoholic beverages
- ☐ Non-prescription drugs
- ☐ Other

WOMEN ONLY: Are you
- ☐ Pregnant (how many months_____)
- ☐ Past menopause

Is there anything else concerning your health that you think the doctor should know about? Yes No

_____

Date_____ Signature_____
☐ Patient ☐ Parent ☐ Guardian

NOTES:_____

_____

_____

NAME _____

DENTAL HISTORY — Please check (✓) Yes No

1. Date of last dental visit_____ Former Dentist _____
   Purpose_____
2. Have you had regular dental care (annually) in the past? ☐ ☐
3. Do you have any oral habits such as clenching, grinding your teeth, or nail biting? ☐ ☐
4. Have you ever had tooth brushing instruction? ☐ ☐
   How often do you brush your teeth?_____
5. Have you ever had instruction in using dental floss? ☐ ☐
   How often do you floss your teeth? _____
6. Are you satisfied with the function and appearance of your teeth? ☐ ☐
7. Have you ever had or do you now have any of the following:
   - ☐ Bridges
   - ☐ Partial dentures
   - ☐ Full dentures
   - ☐ Root canal fillings
   - ☐ Lost fillings
   - ☐ Extractions
   - ☐ Loose teeth
   - ☐ Orthodontic treatment
   - ☐ Swelling in your mouth or jaws
   - ☐ Injuries to your face or jaws
   - ☐ Gum treatments
   - ☐ Surgery in your mouth
   - ☐ Sensitive teeth
   - ☐ Bleeding gums
   - ☐ Sores or lumps in mouth
8. What dental condition concerns you now?_____

_____

TREATMENT AUTHORIZATION