# MEDICAL and DENTAL QUESTIONNAIRE

All information below is confidential ***PLEASE PRINT CLEARLY***

## 1. GENERAL INFORMATION

**Date:** _____

**Name:** _____
first last

**Birthdate:** _____
day month year

**Address:** _____
street apt#

_____
city postal code

**Telephone:** home _____
work _____
cell _____

Occupation: _____ Employer: _____
Family Doctor: _____ Phone#: _____
Closest Relative: _____ Driver Licence#: _____

Person Responsible for this Account: _____ S.I.N.: _____
Dental Insurance Company: _____
Group/Policy#: _____ Certificate/Div#: _____

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

## 2. MEDICAL HISTORY

Date of last physical examination? _____
Are you presently under the care of a physician? _____
Are you presently taking any medications? _____
Have you taken any prolonged medications in the past? _____
Are you pregnant? _____

Do you have OR have you had any of the following ?

| | | | |
|---|---|---|---|
| Heart disorder | Allergy to anesthetics | Diabetes | Scarlet Fever |
| High/low blood pressure | Allergy to medication | Hepatitis/jaundice | Rheumatic fever |
| Sinus problems | Environmental allergy | Tuberculosis | |
| Nervous problems | Psychiatric care | Venereal disease | Other |
| Excessive bleeding | Radiation treatments | Thyroid problems | |
| Fainting spells | Cancer | HIV | |

## 3. DENTAL HISTORY

What is the reason for your visit? _____
When was the last time you visited the dentist? _____
What was done at that time? _____
Do you have any allergy or abnormal reaction to local anesthetic? _____
Do you grind/clench your teeth, or have pain around your ears? _____
Do your gums bleed? Do you have any swelling in your mouth? _____
Are you satisfied with the appearance of your teeth? _____
What changes would you like to make to your teeth? _____

Signed: _____ (patient/guardian/parent)