CONFIDENTIAL PATIENT QUESTIONNAIRE **Date:**______________

Patient is an: Adult Child Dr Mr. Mrs. Ms. Miss.

Patient Name: _________________________________ ***Date of Birth***: _______________ ***Sex***: ______

Patient Address: ____

Home Phone:______________________ ***Work Phone:***______________________***Cellular***: _________________________

Email address: ____

Employer: ______________________________________ ***Occupation:*** ____

Partner/Guardian's Name: _______________________ ***Contact Phone #:*** _____________________________________

Person we can contact in case of an emergency (Other than your family home)

Name: _____________________***Relationship:*** _____________________ ***Contact Phone #:***_________________________

Other Family members/Friends that are patients here at Clinton Dental: ______________________________

Who may we thank for referring you to our office? ____

<u>Primary Insurance Information</u>

Name of Insured: ________________________ **Date of Birth of Insured**_________________________________

Insurance Provider: ______________________

Patients Relationship to Insured **Self** **Spouse** **Child** **Other**

Group Number: _________________ **Certificate Number:** _________________________

Annual Maximum: ____________________ **Basic Coverage: %** **Major Coverage: %**

<u>Secondary Insurance Information</u>

Name of Insured: ________________________ **Date of Birth of Insured**___________________________

Insurance Provider: ______________________

Patients Relationship to Insured **Self** **Spouse** **Child** **Other**

Group Number: _________________ **Certificate Number:** _________________________

Annual Maximum: ____________________ **Basic Coverage: %** **Major Coverage: %**

MEDICAL HISTORY Questionnaire

DDS

To provide the best possible care for our patient, all patients must fill out this questionnaire completely.

	Yes	No	Maybe/Not sure
1 Are you being treated for any medical condition at the present or Have you been treated within the past year?	____	____	______________
If so, why? ______________________________			
2 Was your last medical checkup within the past year?	____	____	______________
3 Has there been any change in your general health in the past year?	____	____	______________
4 Do you have any allergies? (I.e. Hay fever, Latex/rubber)_____________	____	____	______________
5 Have you ever had peculiar or adverse reactions to medicines or injections? (I.e. Penicillin, aspirin, local anesthetics, “dental freezing”)	____	____	______________
6 Are you taking any medications or non-prescription drugs of any kind?	____	____	______________
(IF YES, LIST: ______________________________			

7 Do you have or ever had any of the following? (Please circle all that apply)

*Any heart problems, *Chest pain, *Angina, *Heart attack, *Stroke, *Shortness of breath, *Heart murmur, *Heart transplant, *Heart surgery, *Artificial heart valve, *Infection in the heart (endocarditis), *Heart failure, *Blood pressure problem, *Rheumatic fever, *Mitral valve problems, *Congenital heart disease (from birth or early childhood)
*NONE OF THE ABOVE

	Yes	No	Maybe/Not sure
8 Do you have any condition that could affect your immune system? (I.e. Leukemia, AIDS, HIV infection)	____	____	______________
9 Do you bruise easily or bleed for a prolonged period of time after a cut?	____	____	______________
10 Have you ever been hospitalized for any illness or operations?	____	____	______________
Please explain: ______________________________			

11 Do you have or ever had the following? (Please circle all that apply)

*Hepatitis	*Jaundice	*Liver Disease	*Lung disease	*Tuberculosis	*Asthma	*Steroid Therapy
*Diabetes	*Stomach ulcers	*Prosthetic joints	*Arthritis, type______	*Seizures	*Kidney disease	*Cancer

	Yes	No	Maybe/Not sure
12 Are there any conditions or diseases not listed above that you have or had?	____	____	______________
If so, what? ______________________________			
13 Are there any diseases or medical problems that run in your family? (I.e. Diabetes, cancer or heart disease?) ______________________________	____	____	______________
14 Do you or did you smoke? If so, how much ______________________________	____	____	______________
15 Do you drink alcoholic beverages on a regular basis?	____	____	______________
16 Do you use recreational drugs (such as cocaine or amphetamines?)	____	____	______________
17 Are you nervous during dental treatments? (Indicate by marking scale below) NOT AT ALL – 1 – 2 – 3 – 4 – 5 – VERY ANXIOUS	____	____	______________
18 If you are nervous, would you like us to consider additional techniques along With “freezing”, to help you? ______________________________	____	____	______________
19 Have you ever had any serious trouble with any previous dental treatment?	____	____	______________
20 FOR WOMEN ONLY: Are you pregnant?	____	____	______________
If so, what is the expected delivery date? ______________________________			

CONSENT FORM: ***I acknowledge that the information given to me is true to the best of my knowledge and that the questions have been reviewed with me. Should there be any change to my present health status in the future, I will advise Clinton Dental. I have been informed that my physician may be contacted by letter, email, fax or telephone in order to complete details of my medical history. I hereby consent to my physician providing Clinton Dental, with any information in this regard which may ensure safe dental treatment. Finally, I hereby acknowledge that dental treatment may be delayed until all medical information required by Clinton Dental is received.***

Date:_________________ Patient Signature:___________________________ Witness Signature:______________________

Medical Doctor’s Name:________________________ Phone # and Address:____

Specialist Doctor’s Name:_______________________ Phone # and Address:_______________________________________

Reviewed by Dr. ______________________________ Date: ____

DENTAL HISTORY

Patient Name: ____

Previous Dentist:______________________ For how long __________Last dental exam, xrays, cleaning:_______________________

Why did you leave your last dentist? ____

How often do you have your teeth cleaned? 3mo. ___ 4mo. ___ 6mo. ___ 1 year or longer _______

What is your IMMEDIATE DENTAL concern? ____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

	YES	NO
1. Unhappy with the appearance of your teeth	☐	☐
2. Unfavorable dental experiences	☐	☐
3. Dental fears	☐	☐
4. Problems with the effectiveness or bad reactions to dental anesthetic	☐	☐
5. Orthodontic treatment (braces) when?	☐	☐
6. Periodontal (gum) treatment	☐	☐
7. Bleeding gums	☐	☐
8. Avoid brushing any part of your mouth	☐	☐
9. Part of your mouth sensitive to temperature	☐	☐
10. Do you catch food between your teeth	☐	☐
11. Sore teeth	☐	☐
12. Burning sensation in your mouth	☐	☐
13. Difficulty swallowing	☐	☐
14. An unpleasant taste or odor in your mouth	☐	☐
15. Dry mouth	☐	☐
16. Jaw problems (temporomandibular joint)	☐	☐
17. Stiff neck muscles	☐	☐
18. Tension headaches	☐	☐
19. Clench or grind your teeth	☐	☐
20. Lost any teeth (how long ago?)	☐	☐
21. Are you nervous about your dental treatment	☐	☐

Comments:

<u>Supplemental Denture History</u>:

If you are wearing a partial or complete artificial denture, please complete the following:

- Has your present denture been relined? When?____
- Is your present denture a problem? Describe____
- Are you satisfied with the appearance?____
- Satisfied with the chewing ability?____
- When did you receive your 1st partial or complete denture?____________________________________
- How long have you worn your present denture? ____

Patient Signature:_______________________________

Doctor Signature:_______________________________Date:_______________________________________

CANCELLATION POLICY

We will make every attempt to schedule your appointments at your convenience. When an appointment is booked, that time slot is set aside **just for you**. For this reason if you are unable to keep a scheduled appointment, 2 business days notice is required or a fee of $100 will be charged to your account which must be paid prior to your next visit.

Assignment and Release

I am financially responsible for any balances due on the day of treatment, and I authorize the dentists to release any information for this claim to the insurance company on my behalf if applicable. I authorize that my dental records can be used by the doctor if he so determines. In consideration of the services rendered to me by this dental office I am obligated to pay said office in accordance with its credit terms and policy. I consent to the taking of photographs and x-rays before, during, and after treatment, and to the use of same by the doctor in scientific papers or demonstrations.

I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

Signature of Patient/Guardian: ________________________________ ***Date:***____________________________

Signature of Witness: ____________________________________ ***Date:***____________________________