Medical Questionnaire

NOTE: The information on this form is necessary for our records. It is considered strictly confidential. Please answer all questions.

Patient's Name _____ Occupation _____
Preferred Name _____ Employer _____
Home Address _____ Business Address _____
Mailing Address _____ City & Zip _____
City & Zip _____ Business Phone _____
Home Phone _____ Cell Phone: _____ Social Security Number _____
Age _____ Birthdate _____ Email _____
Sex _____ Marital Status _____ Pharmacy _____ Ph. # _____
Medical Dr. _____

Name of Policy Holder _____ Occupation _____
Social Sec. of Policy Holder _____ Employer _____
Dental Insurance Company _____ Address _____
Birthdate of Policy Holder _____ Business Phone _____

Name of Parents/Spouse

In Case of Emergency: (Closest Relative or Friend)
_____ Address _____
Phone # _____ City & Zip _____
How did you choose our office? _____
Chief complaint _____
Last Dental Visit _____ Last Physical Exam _____

Have you ever had:	Yes	No
Rheumatic Fever	☐	☐
Heart Murmur	☐	☐
Heart Trouble	☐	☐
High Blood Pressure	☐	☐
Anemia	☐	☐
Diabetes	☐	☐
If YES, what is your current A1C? _____		
When did you last have your blood sugar tested? _____		
Yellow Jaundice	☐	☐
Liver Disease	☐	☐
Hepatitis	☐	☐
Kidney or Bladder Disease	☐	☐
Blood Disease	☐	☐
Aids/HIV Positive	☐	☐
Venereal Disease	☐	☐
Stomach or Intestinal Disease	☐	☐
Tumors or Growths	☐	☐
Artificial Joints (hips, knees)	☐	☐
Latex Sensitivity	☐	☐
Are you taking Bisphosphonates (i.e. Fosamax)?	☐	☐
Are you taking any other medication or presently under a physician's care?	☐	☐

List medications, herbs, vitamins _____
_____

Have you ever had:	Yes	No
Arthritis	☐	☐
Asthma or Hay Fever	☐	☐
Tuberculosis	☐	☐
Epilepsy	☐	☐
Are you pregnant?	☐	☐
Have you ever been on cortisone or steroid therapy?	☐	☐
Have you been hospitalized in the past five years? For what? _____	☐	☐
Is there anything else in your medical history of significance?	☐	☐
If yes...what? _____		
Have you ever had a reaction to an anesthetic?	☐	☐
Have you ever had severe bleeding or other complications following an extraction?	☐	☐
Do you snore?	☐	☐
Do you have sleep apnea?	☐	☐
Are you allergic to any drugs, medicines or injections?	☐	☐

List allergies here: _____
_____
_____

1. To the best of my knowledge, all the preceding answers are true and correct. If my health or medications change, I will inform the Doctor of Dentistry at my next appointment without fail.
2. Before treatment can be rendered, adequate radiographs of the teeth and mouth must be taken.
3. In this office we use local anesthetic and other methods of pain control to make our patients more comfortable while receiving dental treatment. Local anesthetic can cause permanent nerve damage.
4. Unless otherwise arranged, **PAYMENT FOR PROFESSIONAL SERVICE IS REQUIRED ON THE DAY THE TREATMENT IS RENDERED.** With prior approval, on certain extended procedures and treatment, payment plans can be arranged. ALL ACCOUNTS OVER 90 DAYS WILL BE ASSESSED A 24% APR FINANCE CHARGE. An additional collection fee of 35% of the unpaid balance due will be added to all accounts sent to the collection agency.
5. Please give at least 48 hours notice if you cannot keep your appointment; otherwise, you will be billed for services scheduled.

Consent for Procedure

This is to certify that I, undersigned, consent to the performing of any and all dental and oral surgery procedures diagnosed as necessary or advisable by Family Dentistry doctors and staff, including the use of sedation or local anesthetic as indicated, and I will assume responsibility for fees associated with those procedures. Your signature below also acknowledges the receipt of notice of the Privacy Practice Act.

Patient's (Parent's) Signature _____ Date _____