

# HEALTH QUESTIONNAIRE

Please answer each question. Circle Yes or No where applicable.

## MEDICAL HISTORY

1. Is patient in good health?..... Yes No
2. Is patient presently under the care of a physician?..... Yes No  
If so, what is the condition being treated \_\_\_\_\_
3. Has patient ever had any serious illness or operation? ..... Yes No
4. Has patient taking any drugs or medication?..... Yes No  
If so, what? \_\_\_\_\_
5. Is patient sensitive or allergic to any drugs?..... Yes No  
If yes, please indicate which drugs: .....
6. Does patient have tendency to colds, sore throats, ear infections?..... Yes No
7. Has the patient reached puberty? \_\_\_\_\_ Yes No  
Menstruated (girls) age \_\_\_\_\_ or voice changed (boys) age \_\_\_\_\_
8. Does patient have, or has any of the following: (Please circle known conditions)

Anemia	Blood Diseases	Rheumatism or Arthritis	Epilepsy
Heart Ailments	Hepatitis, Jaundice or Liver	Head Injuries	Mental Disorders
High Blood Pressure	Disease	Stomach Ulcers	Stroke
Respiratory	Kidney Disease	Difficulty in Swallowing	Glaucoma
Tuberculosis	Tumors or Growths	Venereal Disease	Herpes
Nervous Disorder	Radiation Treatment of any kind	Acquired Immune Deficiency	Sinus Trouble
Diabetes	Allergies	Other _____	
Excessive Bleeding	Asthma or Hay Fever	_____	
Rheumatic Fever	Fainting Spells or Seizures	_____	
	Artificial Prosthesis (Implants)		

9. Does patient have any disease, condition, or problem not listed that you think I should know ..... Yes No  
If so, what? \_\_\_\_\_

## DENTAL HISTORY

1. Date of last dental examination? \_\_\_\_\_
2. Is dental work complete ..... Yes No
3. How often does patient brush teeth? \_\_\_\_\_ Floss? \_\_\_\_\_
4. Has patient ever had an injury to face or jaw?..... Yes No
5. Is patient aware if tooth grinding or clenching habits? ..... Yes No
6. Does patient have any speech problems ..... Yes No
7. Does patient breath mostly through the mouth, and/or are lips usually parted?..... Yes No
8. Has patient ever sucked thumb or finger?..... Yes No  
If yes, until what age? .....
9. Does orthodontic/dental treatment make you nervous?..... Yes No  
If yes, circle:      slightly              moderate              extremely
10. Does your jaw make “clicking” or “popping” sounds when you chew?..... Yes No

## Confidential Patient Information

Patient's Name \_\_\_\_\_  
*Last* *First* *Middle* *Age*

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_

If patient is a minor, give parent's or guardian's name \_\_\_\_\_

Patient's Dentist \_\_\_\_\_

Whom may I thank for referring you to our office? \_\_\_\_\_

## Confidential Responsible Party Information

Name \_\_\_\_\_ Marital Status \_\_\_\_\_  
*Last* *First* *Middle*

Residence \_\_\_\_\_  
*Street* *City* *State* *Zip*

Mailing Address \_\_\_\_\_  
*Street* *City* *State* *Zip*

How long at this Address? \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

Previous Address (If less than 3 yrs.) \_\_\_\_\_  
*Street* *City* *State* *Zip*

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Work Phone \_\_\_\_\_

## Insurance Information

Policy Holder's Name \_\_\_\_\_ Insured Identification # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Union Local No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Insurance Co. Phone \_\_\_\_\_

Policy Holder's Employer \_\_\_\_\_

Do you have dual coverage?  No  Yes If Yes:

Policy Holder's Name \_\_\_\_\_ Insured Identification # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Union Local No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Insurance Co. Phone \_\_\_\_\_

Policy Holder's Employer \_\_\_\_\_

## Emergency Information

Name of nearest relative not living with you \_\_\_\_\_

Complete Address \_\_\_\_\_

Phone \_\_\_\_\_ Relationship \_\_\_\_\_

I understand that where appropriate, credit bureau reports may be obtained

Signature (Parents signature if minor) \_\_\_\_\_

Updates (date & Initial) \_\_\_\_\_