



lockportdentalgroup,p.c.

HEALTH QUESTIONNAIRE

Patient's Name _____ Last/First/Initial _____ Date of Birth _____

Home Phone _____ Cell _____ Email _____ SS# _____

Patient's Address _____ City _____ State _____ Zip _____

Patient's Employment _____ Address _____ City _____ State _____ Zip _____ Work Phone _____

Spouse's or Parent's Name _____ Address _____ City _____ State _____ Zip _____ Home Phone _____

Mr. _____

Mrs. _____

Spouse's or Parent's Place of Employment _____ Address _____ Telephone # _____

Mr. _____

Mrs. _____

Person Responsible for Payment of Account:

Last Name _____ First Name _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____ Home# _____

Social Security # _____ Date of Birth _____

Who may we contact in case of emergency? _____ Phone # _____

Dental Insurance Carrier _____ Previous Dentist _____

MEDICAL HISTORY

1. Who is your physician? _____ Phone # _____ Date of last physical exam _____

2. Are you under the care of a physician? YES or NO
if yes, please explain: _____

3. Have you been hospitalized or had a serious illness in the past 2 years? YES or NO
if yes, please explain: _____

4. Do you have a pacemaker? YES or NO

5. Are you presently taking any medications? Please list: _____ YES or NO

6. Do you need to be pre-medicated with an antibiotic before dental treatment? YES or NO

Please check any illness that you have ever had:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Stroke | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> AIDS | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Sexually Transmitted Diseases | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Previous Bacterial Endocarditis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Asthma | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Hip/Knee Replacement | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Diabetes |

(OVER)

Please Check any illness that you have ever had:

- | | |
|---|--|
| <input type="checkbox"/> Hepatitis A, B or C | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Hemophilia/Abnormal bleeding/Clotting Problems | <input type="checkbox"/> Epilepsy/Seizures |
| <input type="checkbox"/> Alzheimer's/Dementia | <input type="checkbox"/> Liver Disease |

7. Are you taking any blood thinners? YES or NO

8. Please check any drugs you have taken:

- | | | | |
|---|---|------------------------------------|-----------------------------------|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Blood Thinners | <input type="checkbox"/> Insulin | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Cortisone | <input type="checkbox"/> Tranquilizers | <input type="checkbox"/> Digitalis | <input type="checkbox"/> Dilantin |
| <input type="checkbox"/> Nitroglycerine | <input type="checkbox"/> Other _____ | | |

9. Please check any drugs that you have had a bad reaction (allergy) to:

- | | | |
|---|----------------------------------|--|
| <input type="checkbox"/> Dental Anesthetics | <input type="checkbox"/> Codeine | <input type="checkbox"/> Metals (Nickel) |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Valium | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Other Antibiotics | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Other _____ |

10. Have you ever had surgery, radiation therapy or chemotherapy for any condition in your mouth, head or neck? YES or NO

11. Have you ever had abnormal bleeding associated with any previous surgery, extractions, or trauma? YES or NO

12. Have you ever had a serious problem associated with any dental work? YES or NO

13. Do you have frequent or severe headaches? YES or NO

14. Are you pregnant or nursing? YES or NO

15. Are you taking oral contraceptives? YES or NO

16. Do you floss your teeth daily? YES or NO

17. How often do you brush your teeth? _____

18. Do your gums bleed when you brush your teeth? YES or NO

19. Does your jaw joint click, snap or pop? YES or NO

20. Who may we thank for referring you? _____

21. Do you smoke or use tobacco in any form? YES or NO

22. Are you interested in tooth whitening? YES or NO

Patient agrees to be liable for collection cost/expenses in the amount of 35% of the total outstanding indebtedness/amount due, reasonable attorney's fees and disbursements if collection becomes necessary.

I certify that the foregoing information is true and correct.

Patient or Parental/Guardian Signature _____ Date _____

Doctor's Signature _____ Date _____

MEDICAL HISTORY UPDATE

Date _____ Signature _____ Date _____ Signature _____

Date _____ Signature _____ Date _____ Signature _____

Date _____ Signature _____ Date _____ Signature _____

Date _____ Signature _____ Date _____ Signature _____

Date _____ Signature _____ Date _____ Signature _____