Dental Questionnaire

Form 401D

Today's Date: _____ Patient # _____

PATIENT INFORMATION

☐ Mr. ☐ Ms ☐ Miss ☐ Mrs. ☐ Dr.

Name: _____

Address _____

City/State/Zip _____

How long at current address? _____

Phone# _____ SS # _____

Cell Phone _____

Email _____

Birth Date _____ Age _____ ☐ Male ☐ Female

☐ Single ☐ Married ☐ Widowed
☐ Separated ☐ Divorced ☐ Dependent

RESPONSIBLE PARTY
IF OTHER THAN PATIENT

Relationship to patient _____

Name: _____

Address _____

City/State/Zip _____

How long at current address? _____

Phone# _____ SS #_____

Birth Date _____ Age _____ ☐ Male ☐ Female

☐ Single ☐ Married ☐ Widowed
☐ Separated ☐ Divorced

EMPLOYMENT INFORMATION

Employer _____

Work Phone _____

Occupation _____

How Long at Current Job? _____

INSURANCE

Insurance Company _____

Address _____

City/State/Zip _____

Phone # _____

Insured's Employer _____

Insured's Name _____

Relationship to Patient _____

Insured's SS # or Membership # _____

POLICY / GROUP NUMBER _____

PLEASE CHECK ALL DENTAL CONCERNS THAT APPLY TO YOU:

TEETH:

☐ Broken or Chipped
☐ Crooked
☐ Decay
☐ Difficulty Chewing
☐ Discolored
☐ Food Trap Areas
☐ Grinding or Clenching
☐ Loose or Missing Filling
☐ Loose Tooth or Teeth
☐ Missing Tooth or Teeth
☐ Mouth Sores
☐ Sensitive to Temperature Changes
☐ Sensitive to Sweets
☐ Tooth Pain

GUMS:

☐ Bleeding
☐ Pimple or Bump
☐ Sore or Sensitive

JAW / FACIAL PAIN PROBLEMS

☐ Facial Pain
☐ Frequent Headaches
☐ Jaw Clicks
☐ Jaw Pain
☐ Pain in Cheeks or Temples

OTHER CONCERNS OR REASONS FOR VISIT:

_____

_____

☐ Here for a Periodic Examination. No specific Known Dental Problems.

PAST DENTAL HISTORY:

Last Dental Visit _____

Dental Visit Frequency Ever:

_____ Months _____ Years _____ As Needed

Have Tooth Replacements such as Dentures, Partials, Bridges or Implants?

☐ Satisfied ☐ Dissatisfied

Other: _____

Patient Signature _____

LIST ANY MEDICATIONS WHICH HAVE CAUSED AN ALLERGIC REACTION:

Y ☐ N ☐ Antibiotics
Y ☐ N ☐ Aspirin
Y ☐ N ☐ Codeine
Y ☐ N ☐ Iodine
Y ☐ N ☐ Latex
Y ☐ N ☐ Local anesthetics
Y ☐ N ☐ Metals
Y ☐ N ☐ Novocaine
Y ☐ N ☐ Penicillin
Y ☐ N ☐ Plastic
Y ☐ N ☐ Sedatives
Y ☐ N ☐ Sleeping pills
Y ☐ N ☐ Sulfa drugs

Other allergens: _____

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

Y ☐ N ☐ Antibiotics
Y ☐ N ☐ Anticoagulants
Y ☐ N ☐ Blood Thinners
Y ☐ N ☐ Blood Pressure
Y ☐ N ☐ Codeine
Y ☐ N ☐ Cortisone
Y ☐ N ☐ Diet pills
Y ☐ N ☐ Digestive Aids
Y ☐ N ☐ Heart medication
Y ☐ N ☐ Insulin
Y ☐ N ☐ Muscle relaxants
Y ☐ N ☐ Pain Medication
Y ☐ N ☐ Sleeping Pills
Y ☐ N ☐ Tranquilizers

Other current medications: _____

MEDICAL HISTORY

Y ☐ N ☐ Anemia
Y ☐ N ☐ Arthritis
Y ☐ N ☐ Artificial Joint or Prosthetic
Y ☐ N ☐ Asthma
Y ☐ N ☐ Bleeding Easily After a Cut
Y ☐ N ☐ Cancer
Y ☐ N ☐ Chronic Mouth Dryness
Y ☐ N ☐ Current Pregnancy
Y ☐ N ☐ Depression
Y ☐ N ☐ Diabetes
Y ☐ N ☐ Digestive Problems
Y ☐ N ☐ Dizziness
Y ☐ N ☐ Epilepsy or Seizure
Y ☐ N ☐ Headaches
Y ☐ N ☐ Heart Murmur
Y ☐ N ☐ Heart Pacemaker
Y ☐ N ☐ Heart Palpitations
Y ☐ N ☐ Heart Valve Replacement
Y ☐ N ☐ Heart Valves Damaged
Y ☐ N ☐ Hepatitis
Y ☐ N ☐ High Blood Pressure
Y ☐ N ☐ Immune System Disorder
Y ☐ N ☐ Injury to
☐ Face ☐ Mouth
☐ Neck ☐ Teeth
Y ☐ N ☐ Kidney Problems
Y ☐ N ☐ Liver Problems
Y ☐ N ☐ Low Blood Pressure
Y ☐ N ☐ Osteoporosis
Y ☐ N ☐ Radiation Treatment
Y ☐ N ☐ Respiratory Problems
Y ☐ N ☐ Rheumaic Fever
Y ☐ N ☐ Scarlet fever
Y ☐ N ☐ Sinus problems
Y ☐ N ☐ Tuberculosis

Other medical history:
_____
_____

DESCRIBE ANY SERIOUS ILLNESS, MAJOR SURGERY OR CONDITIONS NOT LISTED ABOVE:

Date Description

_____ _____
_____ _____
_____ _____

ARE YOU UNDER A PHYSICIAN'S CARE?

Practitioner Specialty Treatment & Approximate Date

_____
_____

Primary Care Physician _____

IF VISIT IS DUE TO ACCIDENT, PLEASE DESCRIBE:

_____

I authorize the release of a full report of examination findings, diagnosis, treatment program, etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation. I understand that I am responsible for all fees for treatment regardless of insurance coverage.

Patient Signature _____ _____

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment but, in refusing we will not be allowed to process your insurance claims.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for David L. Clark D.D.S..

Please print your name:_____ Please sign your name:_____

Please list any other parties who can have access to your dental information: (This includes step parents, grandparents and any caretakers who can have access to this patients records).

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY DENTAL APPOINTMENTS, TREATMENT AND BILLING INFORMATION VIA:

___CELL ___TEXT ___HOME ___EMAIL ___WORK ___MAIL/POST CARD

I AUTHORIZE INFORMATION ABOUT MY DENTAL HEALTH BE CONVEYED VIA:

___CELL ___TEXT ___HOME ___EMAIL ___WORK ___MAIL/POST CARD

I APPROVE BEING CONTACTED ABOUT SPECIAL SERVICES, EVENTS OR NEW DENTAL INFORMATION VIA:

___CELL ___TEXT ___HOME ___EMAIL ___WORK ___MAIL/POST CARD

OFFICE USE ONLY:

As a Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this acknowledgment but did not because:

____It was emergency treatment ____I could not communicate with the patient

____The patient refused to sign

__The patient was unable to sign because_____

__Other, please describe:_____

Signature of Privacy Officer:_____