

D A V I S V I L L E E N D O D O N T I C S

Welcome To Our Office

In order to aid in evaluating your dental health thoroughly and completely, please complete the following examination questionnaire. This will become part of your office record and will be held in strict confidence.

Patient Information:

Mr. Mrs. Ms. _____
First Name Initial Last Name Date of Birth (M/D/Y)

Address _____ Apt. _____ City _____ Postal Code _____

Home Tel () _____ Cell () _____ E-mail _____

Occupation _____ Employer _____ Business Tel () _____

Insurance Information:

Primary Policy Holder Name _____ Policy Holder's D.O.B. (M/D/Y) _____
 Insurance Company Name _____ Policy/Group# _____ ID# _____

Secondary Policy Holder Name _____ Policy Holder's D.O.B. (M/D/Y) _____
 Insurance Company Name _____ Policy/Group# _____ ID# _____

Name of Spouse/Parent _____ Business Tel () _____
 Family Doctor _____ Tel () _____ Referring Dentist _____

Have you ever had an unfavourable reaction following dental treatment? YES / NO <i>Please discuss this with the doctor.</i>	List of Allergies _____ _____ _____	List of Medications & Reason (include non-prescription drugs) _____ _____ _____
Have you ever had excessive bleeding requiring special treatment? YES / NO Please discuss this with the doctor. YES / NO	_____ _____ _____	_____ _____ _____
Female patients, are you or could you be pregnant or nursing? YES / NO If pregnant, which month? _____	_____ _____ _____	_____ _____ _____

Check off any of the following which you have or have had:

- | | | |
|---|--|---|
| <input type="checkbox"/> Heart trouble/Angina | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stomach ulcer |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Anemia | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Fainting spells |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lupus | <input type="checkbox"/> Sinus trouble |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Nervous disorders | <input type="checkbox"/> Neck injury |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Cortisone treatment | <input type="checkbox"/> Cancer treatment |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Psychiatric treatment | <input type="checkbox"/> Sickle cell disease |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Migraine/Headaches | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Herpes | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Mitral valve prolapsed |
| <input type="checkbox"/> Addictions | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Artificial valve, joint/prosthesis |
| <input type="checkbox"/> TMJ problems | <input type="checkbox"/> Congenital heart defect | <input type="checkbox"/> Blood transfusion |
| <input type="checkbox"/> HIV+/Aids | <input type="checkbox"/> Cardiac pacemaker | <input type="checkbox"/> Tuberculosis (TB) |

Do you have or have you had any other diseases or medical problems not listed on this form? _____

Dental History:

Are you presently in pain? **YES / NO**
 Is any part of your mouth sensitive to the following? **YES / NO**

- Hot Cold Biting Pressure Sweets
 Other _____

Primary complaint: _____

Financial Policy. The major objective of our office is to provide you with the highest quality dental care. Our service is based on a friendly, mutual, but businesslike understanding between doctor and patient. We feel that misunderstanding can be minimized if financial policies are agreed upon at the beginning of treatment.

I hereby state that the above medical history is to the best of my knowledge, accurate and complete. If I ever have any change in my health, or if my medicines change, I will inform the doctor at the next appointment without fail. If deemed advisable, I grant permission for my physician to be contacted for details and advice. I further authorize the taking of radiographs or other diagnostic measures appropriate for a thorough evaluation.

 Signed

 Date