



## HEALTH QUESTIONNAIRE

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Name \_\_\_\_\_  Male  Female

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_ email address \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Place of Employment \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_ Physician Name \_\_\_\_\_

### DENTAL INSURANCE INFORMATION: (FOR THE PERSON WHO CARRIES THE INSURANCE)

Insurance Carrier \_\_\_\_\_ Name \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Group # \_\_\_\_\_ Employer \_\_\_\_\_ Insurer's Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

*Do any of the below conditions apply to you? (Please check yes or no)*

	YES	NO		YES	NO
High Blood Pressure / Hypertension			Anemia		
Low Blood Pressure			Jaundice / Liver Disease		
Heart Murmur			Bleeding Disorder / Hemophilia		
Rheumatic Fever			Kidney Disease		
Mitral Valve Prolapse (MVP)			Organ Transplant		
Angina Pectoris / Chest Pain			Cancer (Type _____)		
Heart Attack			Chemotherapy		
Prosthetic (artificial) Heart Valve			Radiation Therapy		
Irregular / rapid heart beat			Epilepsy / Seizure		
Pacemaker / Implanted defibrillator			Stomach Ulcer		
Heart Disease			Colitis / Intestinal Problems		
Heart or Bypass Surgery			Osteoarthritis		
Malnourishment			Rheumatoid Arthritis / Lupus		
Stroke			Artificial Joints / Screws		
Emphysema			Sexually Transmitted Disease (STD)		
Asthma			AIDS / HIV		
Diabetes (Type _____)			Tuberculosis (TB)		
Thyroid Disease / Goiter			Psychiatric Treatment		
Liver Disease			Alcohol / Substance Abuse		
Hepatitis (Type _____)			Allergy to Latex		
Blood Transfusion			Pregnant / Nursing		
Renal Dialysis			Other (specify)		

Medications \_\_\_\_\_

Allergies \_\_\_\_\_

Hospitalizations/Surgeries \_\_\_\_\_

Other Medical Concerns? \_\_\_\_\_

	YES	NO
Are you satisfied with the color of your teeth?		
Are you interested in cosmetic dentistry?		
Are you happy with the position of your teeth?		
Are you interested in veneers?		
Are you interested in conventional orthodontics?		
Do you grind your teeth while sleeping, exercising, etc?		
Do you experience jaw clicking?		
Do you experience ear / joint pain?		
Do you experience frequent headaches?		
Do you have sensitivity to cold, hot, sweet or pressure to any of your teeth?		
Do you notice yourself with halitosis (bad breath)?		
Do your gums bleed easily?		
Are your gums swollen / tender?		
Have you ever been diagnosed with periodontal disease?		
Do you presently have any crown / bridge work?		
Do you presently have any dental implants?		
Have you in the past needed to premedicate prior to a dental appointment?		
Do you have dry mouth (Xerostomia)?		
Do you bite your lip or cheek?		
Do you get blisters on your lip or mouth?		

**I certify that all the proceeding answers contained in this health history are complete and true. I understand that responding inaccurate could be dangerous to my health and cause adverse reactions during dental treatment. I understand that I am responsible for any errors or omissions that I may have made in completion of this form. It is my responsibility to inform the clinician of any health changes prior to services being rendered. I hereby authorize the Cantwell Dental Group to release the necessary information to secure the payment of third party benefits. I authorize the use of this signature on all insurance submissions. I agree to be responsible for payment of all services rendered if not covered by the dental insurance.**

**If I am not able to keep an appointment I am required to inform Cantwell Dental Group at least 24 hours in advance. If 24 hour notice is not given, I may be charged a \$50 cancellation fee.**

\_\_\_\_\_ Date

\_\_\_\_\_ Patient or Legal Guardian (Signature)



**PATIENT RECORD OF DISCLOSURES**

Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

I wish to be contacted in the following manner:

Home Telephone: \_\_\_\_\_

- Ok to leave message with detailed information
- Leave a voice message with a call back number only
- I prefer you only speak with me

Work Telephone: \_\_\_\_\_

- Ok to leave message with detailed information
- Leave a voice message with a call back number only
- I prefer you only speak with me

Written Communication

- OK to mail to my home address
- OK to mail to my work address

Persons authorized to speak with us?

<u>Name</u>	<u>relationship</u>
_____	_____
_____	_____
_____	_____
_____	_____