

PATIENT QUESTIONNAIRE
(THIS INFORMATION IS STRICTLY CONFIDENTIAL)

NAME _____ SOC. SEC. NO. _____
LAST NAME FIRST NAME MIDDLE INITIAL

BIRTH DATE _____ AGE _____ EMAIL _____ CELL PHONE _____

RES. ADDRESS _____ RES. PHONE _____
STREET CITY STATE ZIP

BUS. ADDRESS _____ BUS. PHONE _____
STREET CITY STATE ZIP

EMPLOYER _____ OCCUPATION _____

MARITAL STATUS (CIRCLE) S - M - W - D _____ REFERRED BY _____

SPOUSE'S NAME _____ SPOUSE'S RES. ADDRESS _____

SPOUSE'S EMPLOYER _____ SPOUSE'S BUS. ADDRESS _____

PARENT OR NEAREST LIVING RELATIVE: _____ RELATIONSHIP _____

RELATIVE'S NAME _____ RELATIVE'S ADDRESS _____

RELATIVE'S PHONE _____ RELATIVE'S EMPLOYER _____

PHYSICIAN _____ PHYSICIAN'S ADDRESS _____

DENTIST LAST VISITED _____ DATE OF VISIT _____

HAVE YOU EVER BEEN TREATED FOR (CIRCLE):

- | | | |
|----------------------------|------------------------------|-----------------------|
| 1 HEART DISEASE | 11 EMPHYSEMA | 21 DIABETES |
| 2 RHEUMATIC FEVER | 12 HAY FEVER | 22 THYROID DISEASE |
| 3 HEART MURMUR | 13 SINUS TROUBLE | 23 EPILEPSY |
| 4 HIGH/LOW BLOOD PRESSURE | 14 ANTIBODY POSITIVE FOR HIV | 24 CANCER |
| 5 CONGENITAL HEART LESIONS | 15 ULCERS | 25 ARTHRITIS |
| 6 ANEMIA | 16 HEPATITIS/JAUNDICE | 26 GLAUCOMA |
| 7 STROKE | 17 CIRRHOSIS | 27 CURRENTLY PREGNANT |
| 8 PROLONGED BLEEDING | 18 LIVER DISEASE | 28 AIDS |
| 9 TUBERCULOSIS | 19 KIDNEY DISEASE | 29 ORGAN TRANSPLANT |
| 10 ASTHMA | 20 VENEREAL DISEASE | 30 NONE OF THE ABOVE |

OTHER MEDICAL PROBLEMS _____

ALLERGIES: Penicillin Local Anesthetics
 Codeine Other Medications (List)

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: _____

REASON FOR THIS DENTAL VISIT _____

FULL PAYMENT FOR TREATMENT IS DUE AT THE END OF EACH VISIT. ALL BALANCES NOT PAID WITHIN THIRTY DAYS OF TREATMENT DATE BEAR INTEREST AT THE RATE OF 1½% PER MONTH. ANNUAL PERCENTAGE RATE IS 18%.

PLEASE CHECK: Cash/Check MasterCard or Visa

INSURANCE COMPANY NAME _____ DRIVER'S LICENSE NO. _____

THIS OFFICE DOES **NOT** SEND STATEMENTS.

THERE WILL BE A \$20 CHARGE FOR ALL BROKEN APPOINTMENTS OR APPOINTMENTS NOT CANCELLED 48 HOURS IN ADVANCE.

THIS OFFICE WILL ATTEMPT TO COMPLETE YOUR TREATMENT AS PROMPTLY AS POSSIBLE. PLEASE ARRIVE TEN MINUTES PRIOR TO YOUR APPOINTED TIME.

TODAY'S DATE _____ SIGNATURE _____