DENTAL HEALTH ASSOCIATES

DENTAL QUESTIONNAIRE

Name: Date:

What prompted you to seek dental care at this time?

How long since your last dental exam? Dental X-Rays?

Do your gums bleed easily, feel tender, or irritated? ☐ Yes ☐ No

Do you experience TMJ problems -jaw joint clicking? ☐ Yes ☐ No

Do you have frequent headaches, neckache, or backache? ☐ Yes ☐ No

Are you self-conscious about the appearance of your teeth? ☐ Yes ☐ No

Is there anything about your smile that you would like to change? ☐ Yes ☐ No

Do you snore or have sleep apnea? ☐ Yes ☐ No

Do you have any history of facial/dental trauma? ☐ Yes ☐ No

Do you have a history of Orthodontics? ☐ Yes ☐ No

If no, are you interested in straighter teeth? ☐ Yes ☐ No

Would you like whiter teeth? ☐ Yes ☐ No

If you have missing teeth, would you consider dental implants? ☐ Yes ☐ No

Are you satisfied with your past dentistry? ☐ Yes ☐ No

Your dally Hygiene routine includes Brushing x per day Flossing x per day

Do you prefer ☐ manual or ☐ electric toothbrush

Do you experience bad breath or halitosis ☐ Yes ☐ No

Please list other family members who will be patients:

Whom may we thank for your referral?

Signature:

DENTAL HEALTH ASSOCIATES **Health Questionnaire**

Patient name:

Birthdate: Patient S.S. #

Address: Height/Weight:

City: State: Zip Code:

Home Phone: Work Phone: Cell Phone:

Occupation: Martial Status: E-Mail:

Insured Name: Employer:

Dental Insurance Co. D.O.B.: ID#:

Emergency Contact/ Relationship/ Phone:

1. Who is your medical doctor? Phone#:
2. When was the last time you saw your doctor?
3. Are you taking, or has a physician prescribed any medications? ☐ Yes ☐ No
   If yes, please list:
4. Do you have any allergies or adverse reactions to: ☐ Medicine ☐ Latex ☐ Food ☐ Other
5. Do you have shortness of breath, hay fever or asthma? ☐ Yes ☐ No
6. Do you have,or have you had hepatitis or liver disease? ☐ Yes ☐ No
7. Do you have an artificial joint? When? Premed Needed? ☐ Yes ☐ No
8. Do you have or have you had heart conditions or surgery or valve replacement? ☐ Yes ☐ No
9. Do you snore or have sleep apnea? ☐ Yes ☐ No
10. Do you have to sleep on more than one pillow? ☐ Yes ☐ No
11. Do you experience TMJ problems or jaw joint clicking? ☐ Yes ☐ No
12. Do you have or have you had high blood pressure? ☐ Yes ☐ No
13. Do you or anyone in your family have a bleeding problem? ☐ Yes ☐ No
14. Do you drink alcohol? ☐ Yes ☐ No If yes, # per week.
15. Do you smoke/use tobacco? ☐ Yes ☐ No If yes, how much?
16. Do you use recreational drugs? ☐ Yes ☐ No
17. Do you have, or have you had: (mark all that apply)

☐ Anemia ☐ Diabetes ☐ Kidney disease ☐ Thyroid disorder ☐ Osteoporosis ☐ Osteopenia
☐ Seizures ☐ Lung disease ☐ Nervous disorder ☐ Arthritis ☐ Cancer ☐ Acid reflux

18. Have you ever been exposed to any sexually transmitted disease or HIV? ☐ Yes ☐ No
    If yes, what type:
19. Female patients- are you pregnant? ☐ Yes ☐ No
20. Is there anything else about your physical condition the dentist should know? ☐ Yes ☐ No
    If yes, explain:
21. To the best of your knowledge, are you in good health? ☐ Yes ☐ No

Patient Signuature: Date:

Initial/Date Initial/Date Intiai/Date