Patient Questionnaire & Health History

Patient's Name _____
Address _____
City _____ State: _____ ZIP: _____
Cell #: _____ Home #: _____
Email Address: _____
DOB: _____Age:___ SSN: __ __ __ - __ __ - __ __ __ __
Employer Name: _____
Employer Address: _____
City: _____ State: _____ ZIP: _____
Occupation: _____How long held? _____
Single___ Married ___ Divorced ___ Widowed ___ Separated _
Name of Spouse: _____Spouse's DOB: _____
Spouse's SSN: __ __ __- __ __ - __ __ __ __
Spouse's Employer Name: _____
Dental insurance policy holder name: _____
Dental Insurance Company: _____
Subscriber/ member ID: _____
Policy Group Number: _____
Secondary Dental Insurance Company: _____
Subscriber/ member ID: _____
Policy Group Number: _____
Name of previous dentist: _____
Last dental visit _____ Reason _____
How did you hear about us?
Relative Friend Internet Yellow Pages Other

The disclosure of information given today is true to date.
If ANY of the disclosed information changes,
patient is responsible to notify Dubois Dentistry.

Signature_____ Date _____

ASA Type: I II III IV V

Do you have or have ever had:	YES	NO
Anemia	___	___
Asthma	___	___
Diabetes	___	___
Epilepsy	___	___
Hepatitis – A, B, C, NON AB	___	___
Aids (HIV Positive OR ARC)	___	___
Allergy to Penicillin	___	___
Allergy to other antibiotics	___	___
Allergy to Codeine	___	___
Allergy to Aspirin	___	___
Allergy to Acetaminophen (Tylenol)	___	___
Allergy to Ibuprofen	___	___
Allergy to metals	___	___
Allergy to latex rubber	___	___
Other Allergies. Please list: _____	___	___
Abnormal heart condition	___	___
Heart Murmur (i.e. mitral valve prolapse)	___	___
Liver or Kidney Disease	___	___
Abnormal bleeding from a cut	___	___
Rheumatic Fever	___	___
Prosthetic joints or valves	___	___
High Blood Pressure	___	___
Hospital admission (within last 2 years)	___	___
Currently Pregnant	___	___

Other physical conditions _____
Do you SMOKE/CHEW tobacco ___ ___
Current medications and purpose
_____
_____
Are you under the care of a physician now? ___ ___
Name of physician_____ Phone #_____

Optional
Below is a list of questions.
Answer any or all that may help us serve you better.

1. What are your main concerns about this visit? _____

_____

2. Do you: A) Dread B) Worry C) Don't mind having dental work done

3. May we ask the reason for leaving your previous dentist? _____

_____

4. What can we do to make your visits more pleasant? _____

_____

5. Has there been any dental treatment recommended to you that have not been done yet? YES NO

_____

6. Have you had an unfavorable dental experience? YES NO

_____

We are interested in your good health. Please let us know if we have not explained things clearly or if you have unanswered questions. We also have printed information available to you on topics such as diet and dental health (braces, bonding, care of children's teeth, pit and fissure sealants, etc.).

Thank you