

## BILLING INFORMATION

RESPONSIBLE PARTY FOR THIS ACCOUNT	LAST NAME	FIRST	MIDDLE	HOME PH.	BUSINESS PH.
	STREET		CITY	STATE	ZIP
EMPLOYER'S NAME AND ADDRESS	NAME				BUSINESS PH.
	STREET		CITY	STATE	ZIP
EMPLOYER'S NAME AND ADDRESS	CASH	PERSONAL CHECK	BANK NAME		
	DENTAL INSURANCE		CARRIER NAME	POLICY NO.	GROUP NO.

Patient Social Security #		PATIENT INFORMATION									
Patient Name	Patient's Occupation	Sex	M F	Date of Birth	Mo.	Day	Yr.	Marital Status	S D	M W	Ht. Wt.
Dentist's Name		ADDRESS						TELEPHONE			
Physician's Name		ADDRESS						TELEPHONE			

Whom may we thank for referring you to this office? \_\_\_\_\_

## ADULT EXAMINATION AND HEALTH HISTORY QUESTIONNAIRE

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

1. Are you experiencing pain from your mouth at this time? \_\_\_\_\_ If so, explain: \_\_\_\_\_
2. How many times have you had your teeth cleaned in the last 5 years? \_\_\_\_\_ When was the last time? \_\_\_\_\_
3. Have you had previous periodontal treatments? \_\_\_\_\_ Dentist, Date \_\_\_\_\_
4. Do your gums bleed? \_\_\_\_\_ When you brush? \_\_\_\_\_ At night in sleep? \_\_\_\_\_
5. Have you noticed any loose teeth? \_\_\_\_\_ Shifting teeth? \_\_\_\_\_
6. Have you noticed any mouth odors or bad tastes? \_\_\_\_\_ For how long? \_\_\_\_\_
7. Have you ever had trench mouth? \_\_\_\_\_ If so, when? \_\_\_\_\_
8. Did either your mother, father, brother, or sister lose all of their natural teeth? \_\_\_\_\_ Which? \_\_\_\_\_
9. Are your teeth sensitive to heat, cold, or sweets? \_\_\_\_\_ Which ones? \_\_\_\_\_
10. Do meats wedge between your teeth? \_\_\_\_\_
11. How often do you brush your teeth? \_\_\_\_\_ Floss your teeth? \_\_\_\_\_
12. Do you often have fever blisters on your lips? \_\_\_\_\_ After dental care? \_\_\_\_\_
13. Have you had your teeth straightened? \_\_\_\_\_ Dentist, Date \_\_\_\_\_
14. Would you be tremendously disturbed if you had to lose your teeth and wear false teeth? \_\_\_\_\_
15. Are you satisfied with the appearance of your teeth? \_\_\_\_\_
16. Have you been under more nervous tension than average lately? \_\_\_\_\_
17. Do you smoke? \_\_\_\_\_ What and how much? \_\_\_\_\_
18. Are you aware of grinding your teeth at night in your sleep? \_\_\_\_\_ Do you hold your teeth together? \_\_\_\_\_
19. Do you have clicking? \_\_\_\_\_ Popping? \_\_\_\_\_ Pain? \_\_\_\_\_ in the jaw joints?
20. Do you have headaches regularly? \_\_\_\_\_ Mornings? \_\_\_\_\_ Evenings? \_\_\_\_\_ After eating? \_\_\_\_\_
21. Do you tend to worry or fret about things that do not happen? \_\_\_\_\_
22. Are you fearful of undergoing periodontal therapy? \_\_\_\_\_ Why? \_\_\_\_\_
23. Have you ever had an extremely frightening experience with dentistry? \_\_\_\_\_ Explain \_\_\_\_\_
24. Have we treated any of your family or friends? \_\_\_\_\_ Who? \_\_\_\_\_
25. Please indicate the items you regularly use to care for your mouth:
 

<input type="checkbox"/> Hand Toothbrush	<input type="checkbox"/> Rubber Stimulator	<input type="checkbox"/> Stimulents	<input type="checkbox"/> Other
<input type="checkbox"/> Electric Toothbrush	<input type="checkbox"/> Toothpicks	<input type="checkbox"/> Water Spray	
<input type="checkbox"/> Dental Floss	<input type="checkbox"/> Perio Aid	<input type="checkbox"/> Disclosing Solution	
26. Do you often give up doing things (trips, parties) because of unexpectedly not feeling well? \_\_\_\_\_
27. Do you consider your general health to be good? \_\_\_\_\_ Fair? \_\_\_\_\_ Poor? \_\_\_\_\_  
Your last physical evaluation was on? \_\_\_\_\_
28. Has your general health changed within the past year? \_\_\_\_\_ Explain: \_\_\_\_\_
29. Have you ever fainted? \_\_\_\_\_ In a dental office? \_\_\_\_\_

## PATIENT INFORMATION HEALTH QUESTIONNAIRE

MEDICAL ALERT
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