NEW PATIENT HEALTH QUESTIONNAIRE

Patient Name_____Date_____

Why have you made this dental appointment?_____
Have you left a previous dentist? Yes No If so, why?_____
Are you in pain or discomfort at this time? ☐Yes ☐No If so, where?_____
Obstacles I see to excellent dental health for myself: (please circle all that apply)
☐I see no obstacles ☐Time away from work or other obligations ☐Fear of pain, surgery, or injections
☐Fear because of past dental experiences ☐Cost of treatment ☐Other_____
I believe my present DENTAL health is: ☐Excellent ☐Good ☐Poor
Please circle the appropriate answer:

1. Do you use tobacco products……..Yes/ No_____
2. Do you have sensitive teeth?.....……...Yes/ No
3. Would like to improve the appearance of my teeth .....Yes/ No
4. Do you frequently suck on hard candy or mints?.....Yes/No
5. Avoid chewing on one side of mouth……..……..Yes/No
6. Been told you have periodontal disease……..……..Yes/No
7. Gums bleed when brushing?.....Yes/No
8. Unusual/frequent jaw or ear aches?.....Yes/No
9. Have a habit of grinding/clenching your teeth?..……...Yes/No
10. Do you have severe or frequent headaches?.....Yes/No
11. Have you worn braces?.....Yes/No
12. Do you get cold sores/fever blisters on your lips?.....Yes/No
13. Do you get canker sores/mouth ulcers?.....Yes/No
14. Have you had surgery in the last 10 years? Yes/No If Yes, reason?_____

Please list all medications and dosages that you take (prescriptions and over-the-counter): _____
_____
_____(*continue list on separate page if necessary)*
Are you allergic to or have difficulty with any of the following substances? ☐Penicillin ☐Tetracycline ☐Latex ☐Aspirin ☐Codeine ☐Dental Anesthetic ☐Sulfa ☐Erythromycin ☐Other Substances___
_____
For Women: Are you pregnant?.....Yes/No
Are you nursing?.....Yes/No
Are you taking birth control pills?.....Yes/No

I believe my current MEDICAL health is: ☐Excellent ☐Good ☐Poor
Have you been hospitalized in the last 5 years? Yes No If Yes, reason? _____
Please list the names and practice of physicians what are currently providing you care:
1._____Phone Number:_____
2._____Phone Number:_____

For the following questions, circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit, you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Heart Murmur (Mitral Valve Prolapse)	Yes	No	Emphysema/Respiratory Disease	Yes	No
Rheumatic Fever	Yes	No	Unintentional Weight Loss/Gain in last year	Yes	No
History of Heart Attack (s)	Yes	No	Osteoporosis Medication(prolia,Boniva,Fosamax,Lasix,etc)	Yes	No
High Blood Pressure	Yes	No	Liver Disease (including Jaundice)	Yes	No
History of Heart Surgery	Yes	No	History of Psychiatric Treatment	Yes	No
History of Rheumatic Fever	Yes	No	Glaucoma	Yes	No
Chest Pain or Angina	Yes	No	Arthritis	Yes	No
Abnormal Heart Condition	Yes	No	Epilepsy	Yes	No
Stroke	Yes	No	History of Cancer	Yes	No
Diabetes	Yes	No	Hemophilia	Yes	No
Hepatitis (any form—A, B, C)	Yes	No	History of Drug or Alcohol Addiction	Yes	No
HIV Positive or AIDS Related Complex	Yes	No	Tuberculosis	Yes	No
Thyroid Problems	Yes	No	Seasonal Allergies/Hay Fever	Yes	No

*Doctor's Use Only*_____
_____
_____

CONSENT:

The information present on these pages is true to the best of my knowledge. The undersigned authorizes the doctor to take x-rays, study models, photographs, or other diagnostic materials deemed appropriate by the doctor to make a thorough diagnosis of my dental health condition. I authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the services required for my dental health. I understand that the doctor will discuss treatment before it is initiated. I further authorize and consent that the doctor choose and employ such assistance as deemed fit.

I understand that the responsibility for payment for professional services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless written financial arrangements have been made and signed by me. In the event of default I promise to pay interest on the indebtedness together with any collection costs and attorney fees as may be required to effect collection

Patient Signature_____Date_____
(Or Responsible Party)
Doctor Signature_____Date_____