CONFIDENTIAL PATIENT QUESTIONNAIRE

Your cooperation in completing both pages of the questionnaire is essential to help us provide you with the highest possible standard of dental care. All information is strictly confidential and will remain with this office.

NAME _____ DATE _____
Last First Initial

DATE OF BIRTH _ _ / _ _ / _ _ _ _ SEX: Male/Female OCCUPATION _____
DD MM YEAR

Do you have any family members attending this clinic? If so, please specify list.

_____

HOW DID YOU HEAR ABOUT YORK DENTAL? _____

ADDRESS _____
Street Apt # City Prov. Postal Code

HOME PHONE_____ BUSINESS _____ CELL _____

EMAIL _____

DENTAL INSURANCE YES / NO NAME OF INSURANCE COMPANY _____

PERSON RESPONSIBLE FOR ACCOUNT: q SAME AS ABOVE OR _____

_____
Name Address Phone

IN CASE OF EMERGENCY _____
Name Relation phone number

MEDICAL HISTORY

1. Date of last medical exam with family Doctor_____
2. Are you currently under the care of a physician? ❑ YES ❑ NO
3. Name of Physician _____ Phone _____
4. Are you having dental discomfort at this time? ❑ Yes ❑ No
   Please specify _____
5. Have you been under regular care by a dentist? ❑ Yes ❑ No
6. Previous Dentist? _____ Last visit? _____
7. What was done at that time? _____
8. Have you ever had a problem with local or general anesthetic? ❑ Yes ❑ No
9. Are you tense during dental visits? ❑ Yes ❑ No

Please complete next page

10. List of current medication(s) _____

_____

11. Do you have any allergies? ie: Penicillin. ❑ Yes ❑ NO

If yes, please specify _____

12. Do you use tobacco products? ❑ YES ❑ NO Frequency per day? _____

13. Have you ever suffered from or been treated for? (Please circle)

Anemia	*Dizzy Spells / Fainting*	*Hepatitis A B C*	*Pacemaker*
Arthritis	*Drug Dependence*	*Herpes*	*Psychiatric Problems*
Artificial Joints/Prosthesis	*Earaches*	*High Blood Pressure*	*Respiratory Problems*
Artificial Valve	*Eating Disorder*	*HIV / AIDS*	*Scarlet Fever*
Asthma	*Endocarditis*	*Hives*	*Sinus Problems*
Blood Disorder	*Emphysema*	*Jaundice*	*Stroke*
Cancer	*Epilepsy*	*Latex Allergy*	*Thyroid Problems*
Chemo Therapy/Radiation	*Excessive Bleeding*	*Liver Problems*	*Tuberculosis*
Chest Pain	*Headaches*	*Low Blood Pressure*	*TMD (Jaw pain)*
Cholesterol	*Hearing Problems*	*Mobility (ie: wheelchair)*	*Tumors*
Cold Sores / Herpes	*Heart Disease*	*Multiple Sclerosis*	*Ulcer*
Diabetes	*Heart Murmur*	*Osteoporosis*	

14. Are there other medical concerns or conditions not listed above? ❑ Yes ❑ NO

If yes, Please specify _____ _____

15. Women: Are you pregnant? ❑ YES ❑ NO If yes how many weeks?_____ _____

16. Do your gums feel tender or swollen? ❑ Yes ❑ No
17. Are you aware of any lumps or swelling in your mouth? ❑ Yes ❑ No
18. Do you wish to keep your natural teeth? ❑ Yes ❑ No
19. Would you be interested in improving the appearance of your teeth? ❑ Yes ❑ No
20. Describe in your own words what you would like done with your teeth?

_____

_____

21. Do you currently experience? (Please Circle)

Loose Teeth	Bleeding Gums	Popping / Clicking in the jaw joints
Sensitive Teeth	Bad Breath	Unsatisfactory Dentures
Neck Pain	Missing Teeth	Spaced or Crooked teeth
Nosebleeds	Gagging	Sore Gums
TMD (Jaw pain)		

INFORMED CONSENT

I, the undersigned, consent to the performing of the dental procedures agreed to be necessary or advisable, and I will assume responsibility for fees associated with those procedures.

_____ _____

Patient (Parent/Guardian) Signature Date