

## We Would Like to Get to Know You Better!

Full name \_\_\_\_\_ Gender:  Male  Female Date \_\_\_\_\_  
Phone (Hm) (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ (Wk) (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ (Cell) (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Email \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Drivers License # \_\_\_\_\_ Marital status \_\_\_\_\_ Spouse's name \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Work Hours \_\_\_\_\_  
Contact in case of emergency \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
When was your last dental appointment? \_\_\_\_\_ Person responsible for your dental investment? \_\_\_\_\_  
How did you hear about us? \_\_\_\_\_ Why did you leave your last dentist? \_\_\_\_\_

## We Want to Take Care of Your Concerns and Needs First...

What are your present dental problems? \_\_\_\_\_

Do you avoid brushing any part of your mouth?  Yes  No

Do your gums bleed when brushing?  Yes  No

Are your teeth sensitive to sweets, hot/cold, or biting pressure?  Yes  No

I want to know about longer lasting solutions.  Yes  No

Are you dissatisfied with your teeth and their appearance?  Yes  No

Does dental treatment make you nervous?  Very  Moderately  Slightly  No

I think my dental health is...  Excellent  Good  Fair  Poor

If I could change my smile I would make my teeth...  Whiter  Straighter  Close Spaces  Repair Chips

Other concerns/needs of mine are \_\_\_\_\_

## For Insurance Purposes...

Name of policy holder \_\_\_\_\_ Policy holder Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Policy holder's date of birth \_\_\_\_\_ Employer \_\_\_\_\_ Name of Ins. Co. \_\_\_\_\_

Insurance company's Phone \_\_\_\_\_ Group # \_\_\_\_\_ Ins. Co. Address \_\_\_\_\_

Are you covered by another plan? If so please complete the following...

Name of policy holder \_\_\_\_\_ Policy holder Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Policy holder's date of birth \_\_\_\_\_ Employer \_\_\_\_\_ Name of Ins. Co. \_\_\_\_\_

Insurance company's Phone \_\_\_\_\_ Group # \_\_\_\_\_ Ins. Co. Address \_\_\_\_\_

I certify that I, and/or my dependent(s), have insurance coverage and assign directly to Horizons Dentistry all insurance benefits, if any, otherwise payable to th Dr. for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named dentist may use my health care information and may disclose such information to my insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Relationship to patient \_\_\_\_\_

# HEALTH QUESTIONNAIRE

PatientName: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Gender: Male Female

## Dental History

Place a mark to indicate if you have had any of the following:

- |     |    |                   |     |    |                          |     |    |                                  |
|-----|----|-------------------|-----|----|--------------------------|-----|----|----------------------------------|
| Yes | No | Bad breath        | Yes | No | Blisters on lip or mouth | Yes | No | Burning sensation on tongue      |
| Yes | No | Dry mouth         | Yes | No | Orthodontic Treatment    | Yes | No | Sores or growths in your mouth   |
| Yes | No | Grinding teeth    | Yes | No | Jaw Pain or Tiredness    | Yes | No | Cigarette, pipe or cigar smoking |
| Yes | No | Fingernail biting | Yes | No | Clicking or Popping Jaw  | Yes | No | Food collection between teeth    |
| Yes | No | Mouth breathing   | Yes | No | Periodontal treatment    | Yes | No | Loose teeth or broken fillings   |
|     |    |                   | Yes | No | Lip or cheek biting      | Yes | No | Chew on one side of mouth        |

How many times a day do you brush? \_\_\_\_\_ How many times a week do you floss? \_\_\_\_\_

## Medical History

List any medications you are currently taking and the correlating diagnosis. Including all over-the-counter medications and herbs: \_\_\_\_\_

Place a mark to indicate if you have had any of the following:

- | Y | N | Y                    | N | Y                 | N | Y               | N |                      |  |
|---|---|----------------------|---|-------------------|---|-----------------|---|----------------------|--|
|   |   | *Pre-Med             |   | AIDS              |   | Allergy - Latex |   | Nervous Disorders    |  |
|   |   | Allergy - Penicillin |   | Allergy - Sulfa   |   | Anemia          |   | Cortisone Treatments |  |
|   |   | Artific. Heart Valve |   | Artificial Joints |   | Asthma          |   | Back Problems        |  |
|   |   | Blood Disease        |   | Cancer            |   | Other           |   | Cough, persis/bloody |  |
|   |   | Epilepsy             |   | Tumors            |   | Pacemaker       |   | Fainting/Dizziness   |  |
|   |   | Diabetes             |   | HIV               |   | Chemotherapy    |   | Congen. Heart Lesion |  |
|   |   | Glaucoma             |   | Head Injuries     |   | Heart Disease   |   | High Blood Pressure  |  |
|   |   | Heart Trouble        |   | Hep-A             |   | Heart Murmur    |   | Low Blood Pressure   |  |
|   |   | Herpes               |   | Hep-B             |   | Implants        |   | Radiation Treatment  |  |
|   |   | Jaundice             |   | Hep-C             |   | Liver Disease   |   | Respiratory Problems |  |
|   |   | Mental Disorders     |   | Kidney Disease    |   | Allergy - Other |   | Sinus Problems       |  |
|   |   | Venereal Disease     |   | Pneumonia         |   | Scarlet Fever   |   | Circulatory Problems |  |
|   |   | Rheumatic Fever      |   | Rheumatism        |   | Tuberculosis    |   | Chemical Dependency  |  |
|   |   | Stomach Problems     |   | Stroke            |   | Ulcers          |   | Mitral Valve Prolaps |  |
|   |   | Excessive Bleeding   |   | Arthritis         |   |                 |   |                      |  |

1. Are you in good health? Yes No
2. Are you now under the care of a physician? Yes No
3. The name and address and Phone # of my physician is: \_\_\_\_\_

4. Have you ever had a serious illness or operation? Yes No  
If so, what? \_\_\_\_\_

### Women Only

Are you pregnant, nursing or taking birthcontrol pills? _____	Yes No
If pregnant, # of weeks: _____	

### Updates:

Patient/Guardian Signature	DDS Initials	Date
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1. Have you ever used any diet drugs such as Pondimin, "Phen-Phen" or "Redux"? Yes No
2. Have you ever been treated with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma, Fosamax or metastatic cancer? Yes No
3. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? Yes No
4. Do you wear a cardiac pacemaker, or have you had any heart surgery? Yes No
5. Have you ever had a local anesthetic (Novacaine, etc.)? Yes No
6. Have you ever had any unfavorable reaction from a local anesthetic? Yes No
7. Have you had any serious trouble associated with any previous dental treatment? Yes No
8. Do you have any systemic disease, condition, or problem not listed that you think we should know about? Yes No  
If so, what? \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Relationship to patient \_\_\_\_\_

I have read and review all the above information and answered all the questions to the best of my knowledge. Authorization must be signed by the patient, or nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

Doctor Signature: \_\_\_\_\_ Date: \_\_\_\_\_