Adult Personal and Health Questionnaire

Name:_____ Gender: M or F D.O.B:_____ Age:_____ SSN:___-___-_____

Home Address:_____ City:_____ State:_____ Zip Code:_____

Home Phone:(____)_____-_____ Mobile Phone:(____)_____-_____ Email:_____

Marital Status:_____ Spouse's Full Name:_____

Employer:_____ Occupation:_____ Number of years employed:_____

How did you hear about our office:_____

Preferred Appointment Days: Mo: ◯ am ◯ pm Tu: ◯ am ◯ pm We: ◯ am ◯ pm Th: ◯ am ◯ pm Fr: ◯ am ◯ pm

Medical History

Have you ever been treated for: (Please circle **Y** for YES and **N** for NO)

Y / N	Endocrine Problems	Y / N	Prolonged Bleeding	Y / N	Hepatitis	Y / N	Diabetes	Y / N	Arthritis
Y / N	Nervous Disorder	Y / N	Heart Problems	Y / N	Cancer	Y / N	Liver Problems	Y / N	Asthma
Y / N	Rheumatic Fever	Y / N	Bone Disorder	Y / N	Fainting	Y / N	Birth Defects	Y / N	AIDS/HIV

Y / N Allergies: (Please list)_____ Other conditions not listed:_____

Do you now or have you ever taken bisphosphonates, including Fosamax, Didronel, Boniva, Aredia, Actonel, Skelid, or Zometa?_____ If so, which one:_____ Other medication(s):_____

Are you under the care of a physician?_____ If yes, why?_____

Y / N Are you pregnant? If yes, how far along? _____ (Waiver from Physician required for radiographs.)

Dental History

Y / N Have you had prior orthodontic treatment?
Y / N Have there been any injuries to the face, mouth or teeth?
Y / N Do you have any problems with speech?
Y / N Have you been informed of any missing teeth?
Y / N Are any of your teeth sensitive or sore?
Y / N Do you have any cavities not filled?
Y / N Do you have any gum problems?

TMJ History

Y / N Do you clinch and grind your teeth?
Y / N Has the jaw ever locked or slipped out of place?
Y / N Do you have frequent headaches?
Y / N Do you have pain or ringing in the ears?
Y / N Have you experienced any discomfort or clicking of the jaw

General Dentist:_____ Last Dental Cleaning:_____ How often do you brush:_____ Floss_____

Dentist's Address:_____ City:_____ State:_____ Zip Code:_____

Responsible Billing Party Information

Name:_____ Relationship to Pt:_____ Gender: M or F D.O.B:_____

Home Address:_____ City:_____ State:_____ Zip Code:_____

Home Phone:(___)_____-_____ Mobile Phone:(___)_____-_____ Work Phone:(___)_____-_____

SSN:_____-_____-_____ Email:_____

Marital Status:_____ Spouse's Full Name:_____

Employer:_____ Occupation:_____ Number of years employed:_____

Insurance Information Do you have a second Dental Insurance policy? ◯ **Yes** ◯ **No**

Policy Holder's Full Name:_____ SSN:_____-_____-_____ D.O.B:_____

Insurance Company:_____ Policy ID Number:_____ Group Number:_____

Insurance Company's Phone Number:(____)_____-_____ Second Phone Number:(____)_____-_____

Insurance Company Address:_____ City:_____ State:_____ Zip:_____

Employer:_____

Employer's Address:_____ City:_____ State:_____ Zip Code:_____

Relationship to patient:_____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and that it is my responsibility to inform the office of any changes to my child's medical status. If the office accepts my insurance, I am responsible for payment of any co-payment, deductibles or any fees that my insurance does not cover.

Patient's Signature:_____ Date:_____