CONFIDENTIAL PATIENT QUESTIONNAIRE

Today's date:_____

PATIENT INFORMATION

NAME Last_____First_____Middle Initial_____**SEX**: □ M □ F **BIRTHDATE**____/____/____

SOCIAL SECURITY #_____ **MARITAL STATUS**: □ single □ married □ divorced □ widowed

ADDRESS Street_____Apt.#_____City_____State_____Zip code_____

HOME PHONE_____**CELL PHONE**_____**EMAIL**_____

EMPLOYER_____**OCCUPATION**_____**WORK PHONE**_____

PERSON RESPONSIBLE FOR ACCOUNT _____ **PHONE**_____

ADDRESS(if different than above) Street_____Apt.#_____City_____State_____Zip code_____

EMERGENCY CONTACT (relative not living with you) _____ **PHONE**_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?_____

REASON FOR VISIT_____

MEDICAL HISTORY

Please rate your overall health: □ excellent □ good □ fair □ poor

Physician: Name_____ Phone_____ last complete physical____/____/____

Are you allergic to or have you reacted adversely to any of the following medications?

□ penicillin
□ codeine
□ erythromycin
□ aspirin
□ local anesthetics
□ nitrous oxide
□ latex
□ other_____

Do you smoke or use tobacco products? □ yes □ no

If yes, type and quantity _____

Are you currently under a doctor's care? □ yes □ no

If yes, for what reason?_____

WOMEN are you:
□ pregnant
□ nursing
□ taking birth control pills

Please list any medications, pills, or drugs you are taking (and reason):_____

_____

_____

Please check if you have or have had any of the following:

□ HIV/AIDS	□ excessive bleeding	□ mental disorders/psychiatric care
□ allergies	□ glaucoma	□ nervous disorders
□ Alzheimer's	□ head injuries	□ heart surgery/pacemaker
□ anemia	□ heart disease	□ chemotherapy/radiation
□ arthritis	□ heart murmur/mitral valve prolapse	□ rheumatic fever
□ artificial joints	□ hepatitis - A or B	□ sinus problems
□ asthma	□ herpes – oral or genital	□ STDs
□ cancer	□ high or low blood pressure	□ stomach problems/ulcers
□ chest pain	□ hypoglycemia	□ stroke
□ diabetes	□ kidney disease	□ thyroid - hyper or hypo
□ dizziness/fainting	□ liver disease	□ tuberculosis
□ epilepsy	□ lung disease/ respiratory problems	□ tumors

Have you ever had any serious illnesses not listed above? □ no □ yes -- please describe_____

DENTAL HISTORY

How long has it been since your last dental visit?_____x-rays (and type)?_____

Are you currently having any problems? (please specify)_____

What priority do you give your teeth (10 being highest)? 1 2 3 4 5 6 7 8 9 10

What would you like to change regarding the appearance of your teeth?_____

How often do you brush?_____floss?_____

Are you happy with the color of your teeth? □ yes □ no

Have you ever been treated or recommended for treatment of periodontal disease? □ yes □ no when?_____

Please rate your overall dental health:
□ excellent
□ good
□ fair
□ poor

Are any of the following concerns for your dental care:
□ fear of pain
□ cost of treatment
□ missing work time

Please describe your attitude toward dental treatment:
□ very accepting
□ somewhat accepting
□ neutral
□ somewhat resistant
□ uncomfortable/resistant

Do you experience any of the following:
□ headaches
□ neck aches
□ bleeding gums
□ sensitivity
□ clenching/grinding

DENTAL INSURANCE INFORMATION

INSURED'S NAME_____SOCIAL SECURITY #_____ BIRTHDATE____/____/____

INSURANCE COMPANY NAME_____ GROUP NUMBER_____

INSURANCE COMPANY ADDRESS_____PHONE_____

SECONDARY INSURANCE

INSURED'S NAME_____SOCIAL SECURITY #_____ BIRTHDATE____/____/____

INSURANCE COMPANY NAME_____ GROUP NUMBER_____

INSURANCE COMPANY ADDRESS_____PHONE_____

PHOTOGRAPHIC RELEASE: Your initials below indicate your consent for our office to use, reproduce, and/or publish photographs that we may take that may be used for educational or marketing purposes.

Patient Initials_____

I hereby certify that I have told Dr. Weinstein the truth about my medical and dental condition to the best of my ability.
Office policy requests that payment made at the time services are rendered. Financial arrangements are available and must be made IN ADVANCE of treatment. I understand that service charges are incurred for late cancelled and all failed appointments, and returned checks. Accounts past due over 60 days will accrue interest charges of 1½ % per month. In the event that my account becomes delinquent, I, or the responsible party will be responsible for all attorney's fees and all costs necessary for collection.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY_____**DATE**_____

FOR OFFICE USE ONLY: REVIEWED BY:_____DATE_____ □ HIPPA

modified 10/2006