

# CONFIDENTIAL INFORMATION QUESTIONNAIRE

PATIENT'S NAME		LAST	FIRST	MIDDLE	DATE OF BIRTH	SEX	SOCIAL SECURITY #
PATIENT'S ADDRESS		STREET	APT#	CITY	STATE	ZIP	EMAIL HOME PHONE
MARITAL STATUS <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> UNDER AGE 18		PATIENT'S/GUARDIAN'S EMPLOYER			OCCUPATION		
WORK ADDRESS		STREET	CITY	STATE	ZIP	CELL PHONE	WORK PHONE OK TO CALL WORK <input type="checkbox"/> YES <input type="checkbox"/> NO
SPOUSE'S NAME		LAST	FIRST	MIDDLE	SPOUSE'S EMPLOYER		OCCUPATION
WORK ADDRESS		STREET	CITY	STATE	ZIP	CELL PHONE	WORK PHONE OK TO CALL WORK <input type="checkbox"/> YES <input type="checkbox"/> NO
PERSON WE CAN CONTACT IN CASE OF AN EMERGENCY (OTHER THAN YOUR FAMILY HOME)							
NAME		RELATIONSHIP		HOME #	WORK #	CELL #	
OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE				WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE			
INSURANCE COVERAGE <input type="checkbox"/> YES <input type="checkbox"/> NO		INSURANCE COMPANY NAME		ADDRESS		PHONE	
SUBSCRIBER'S NAME		PATIENT'S RELATIONSHIP TO SUBSCRIBER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT		SUBSCRIBER'S DATE OF BIRTH		SUBSCRIBER'S SSN	
GROUP/PROGRAM NUMBER		EMPLOYER (IF DIFFERENT FROM ABOVE)			EMPLOYER ADDRESS		
SECONDARY COVERAGE <input type="checkbox"/> YES <input type="checkbox"/> NO		INSURANCE COMPANY NAME		ADDRESS		PHONE	
SUBSCRIBER'S NAME		PATIENT'S RELATIONSHIP TO SUBSCRIBER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT		SUBSCRIBER'S DATE OF BIRTH		SUBSCRIBER'S SSN	
GROUP/PROGRAM NUMBER		EMPLOYER (IF DIFFERENT FROM ABOVE)			EMPLOYER ADDRESS		

## ASSIGNMENT & RELEASE:

I hereby authorize my insurance benefits to be paid directly to the dentists. I am financially responsible for any balances due and authorize the dentists to release any information for this claim. I authorize that my records can be used by the doctor if he so determines.

In consideration of the services rendered to me by this dental office I am obligated to pay said office in accordance with its credit terms and policy.

I consent to the making of videotapes, photographs, and x-rays before, during, and after treatment, and to the use of same by the doctor in scientific papers or demonstrations.

I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Eaglesoft Medical History

Patient Name: #####

Birth Date:

Date Created: #####

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication

Are you under a physician's care now?  Yes  No If yes \_\_\_\_\_

Have you ever been hospitalized or had a major operation?  Yes  No If yes \_\_\_\_\_

Have you ever had a serious head or neck injury?  Yes  No If yes \_\_\_\_\_

Are you taking any medications, pills, or drugs?  Yes  No If yes \_\_\_\_\_

Do you take, or have you taken, Phen-Fen or Redux?  Yes  No If yes \_\_\_\_\_

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Yes  No If yes \_\_\_\_\_

Are you on a special diet?  Yes  No

Do you use tobacco?  Yes  No

Women: Are you...

Pregnant/Trying to get pregnant?  Nursing?  Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin  Penicillin  Codeine  Acrylic  
 Metal  Latex  Sulfa Drugs  Local Anesthetics

Other?  If yes \_\_\_\_\_

Do you use controlled substances?  Yes  No If yes \_\_\_\_\_

Do you have, or have you had, any of the following?

AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A <input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No
Anemia <input type="radio"/> Yes <input type="radio"/> No	Easily Winded <input type="radio"/> Yes <input type="radio"/> No	Herpes <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No
Angina <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Rheumatism <input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Hives or Rash <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No
Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No
Asthma <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No
Blood Disease <input type="radio"/> Yes <input type="radio"/> No	Frequent Cough <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Spina Bifida <input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No	Leukemia <input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No
Breathing Problems <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Genital Herpes <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No
Cancer <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Hay Fever <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No
Chest Pains <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Ulcers <input type="radio"/> Yes <input type="radio"/> No
Convulsions <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No	Venereal Disease <input type="radio"/> Yes <input type="radio"/> No
			Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No

Have you ever had any serious illness not listed  Yes  No If yes \_\_\_\_\_

Comments:

\_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date: \_\_\_\_\_

# DENTAL HISTORY

Referred by \_\_\_\_\_ How would you rate the condition of your mouth?  Excellent  Good  Fair  Poor

Previous Dentist \_\_\_\_\_ How long have you been a patient? \_\_\_\_\_ Months/Years

Date of most recent dental exam \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of most recent x-rays \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of most recent treatment (other than a cleaning) \_\_\_\_/\_\_\_\_/\_\_\_\_

I routinely see my dentist every:  3 mo.  4 mo.  6 mo.  12 mo.  Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? \_\_\_\_\_

## PLEASE ANSWER YES OR NO TO THE FOLLOWING:

YES NO

### PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [ ] \_\_\_\_\_  YES  NO
2. Have you had an unfavorable dental experience? \_\_\_\_\_  YES  NO
3. Have you ever had complications from past dental treatment? \_\_\_\_\_  YES  NO
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? \_\_\_\_\_  YES  NO
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? \_\_\_\_\_  YES  NO
6. Have you had any teeth removed? \_\_\_\_\_  YES  NO

### SMILE CHARACTERISTICS

7. Is there anything about the appearance of your teeth that you would like to change? \_\_\_\_\_  YES  NO
8. Have you ever whitened (bleached) your teeth? \_\_\_\_\_  YES  NO
9. Have you felt uncomfortable or self conscious about the appearance of your teeth? \_\_\_\_\_  YES  NO
10. Have you been disappointed with the appearance of previous dental work? \_\_\_\_\_  YES  NO

### BITE AND JAW JOINT

11. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) \_\_\_\_\_  YES  NO
12. Do you / would you have any problems chewing gum? \_\_\_\_\_  YES  NO
13. Do you / would you have any problems chewing bagels, baguettes, protein bars, or other hard foods? \_\_\_\_\_  YES  NO
14. Have your teeth changed in the last 5 years, become shorter, thinner or worn? \_\_\_\_\_  YES  NO
15. Are your teeth crowding or developing spaces? \_\_\_\_\_  YES  NO
16. Do you have more than one bite and squeeze to make your teeth fit together? \_\_\_\_\_  YES  NO
17. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? \_\_\_\_\_  YES  NO
18. Do you clench your teeth in the daytime or make them sore? \_\_\_\_\_  YES  NO
19. Do you have any problems with sleep or wake up with an awareness of your teeth? \_\_\_\_\_  YES  NO
20. Do you wear or have you ever worn a bite appliance? \_\_\_\_\_  YES  NO

### TOOTH STRUCTURE

21. Have you had any cavities within the past 3 years? \_\_\_\_\_  YES  NO
22. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? \_\_\_\_\_  YES  NO
23. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? \_\_\_\_\_  YES  NO
24. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? \_\_\_\_\_  YES  NO
25. Do you have grooves or notches on your teeth near the gum line? \_\_\_\_\_  YES  NO
26. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? \_\_\_\_\_  YES  NO
27. Do you get food caught between any teeth? \_\_\_\_\_  YES  NO

### GUM AND BONE

28. Do your gums bleed when brushing or flossing? \_\_\_\_\_  YES  NO
29. Have you ever been treated for gum disease or been told you have lost bone around your teeth? \_\_\_\_\_  YES  NO
30. Have you ever noticed an unpleasant taste or odor in your mouth? \_\_\_\_\_  YES  NO
31. Is there anyone with a history of periodontal disease in your family? \_\_\_\_\_  YES  NO
32. Have you ever experienced gum recession? \_\_\_\_\_  YES  NO
33. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? \_\_\_\_\_  YES  NO
34. Have you experienced a burning sensation in your mouth? \_\_\_\_\_  YES  NO

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_