Dental Questionnaire

Your Dentist's Name ______________________ for how long: __________

How frequently have you had your teeth cleaned during the past 5 years:

❑ Less than once a year ❑ Once a year ❑ Twice a year ❑ Three times a year ❑ Four times a year

Mo/Year of your last dental exam__________ Mo/Year of your last dental x-rays__________

Are you presently satisfied with the condition of your mouth and teeth (circle one):

❑ Very satisfied ❑ Satisfied ❑ It's O.K. ❑ Somewhat dissatisfied ❑ Very dissatisfied

YES NO

- ❑ ❑ Do you presently have any pain, discomfort or impaired function related to your mouth?
  If yes, please describe? ______________________
- ❑ ❑ Are you currently aware of any infection in your mouth?
  If yes, please describe: ______________________
- ❑ ❑ Are you currently taking any antibioitics for infection? If so, what: ______________
- ❑ ❑ Do your gums ever bleed? If so, when: ______________________
- ❑ ❑ Do you have a problem with bad breath or have any friends or family made you aware of this?
- ❑ ❑ Are you interested in replacing lost teeth?
- ❑ ❑ Do you ever have aches or pains in your jaw joints, ears, face, neck or head?
- ❑ ❑ Are any of your teeth tender when you chew hard foods?
- ❑ ❑ Are any of your teeth more sensitive to: cold, hot, sweets, certain foods or drinks?
- ❑ ❑ Are any particular teeth very sensitive or painful? When? ______________
- ❑ ❑ Are you concerned about gum recession around any of your teeth?
- ❑ ❑ Are you concerned about the appearance of your teeth or mouth?
- ❑ ❑ Have you ever had Orthodontic treatment? ❑ With braces ❑ With removable appliances
  When did you go through Orthodontic care? ______________
- ❑ ❑ Have you ever received Periodontal treatment? ❑ Scaling/root planing ❑ Gum surgery
  When did you go through Periodontal care? ______________

Check any of the following that describe you or makes dental treatment easier for you:

- ❑ I tolerate most dental care reasonably well and usually require minimal use of anesthesia
- ❑ I appreciate the use of local anesthetic - it allows me to tolerate most dental care reasonably well
- ❑ I tolerate shots in my mouth when they are given well
- ❑ I like the benefits of nitrous oxide (laughing gas)
- ❑ I prefer to be sedated for any surgical treatment
- ❑ I prefer to be sedated for any lengthy surgical care
- ❑ I have a hard time sitting in the dental chair for more than an hour
- ❑ I have a hard time sitting in the dental chair very long due to a neck, back, spine problem
- ❑ I have difficulty when tilted back in the dental chair (dizziness, breathing difficulty, ______________

What are your goals or priorities for the health, function and appearance of your teeth & mouth:
(rate each item from 1 to 5 with 1 being your lowest priority and 5 your highest - you can use any number more than once)

____Be able to chew food and eat what I enjoy

____Preserve my teeth & avoid dentures

____Be free of infection

____Be free of mouth pain & tenderness

____ Avoid removable bridgework

____ For my mouth to look nice when I smile

____Make my teeth look good

____ Have a healthy and hassle-free mouth

______________________ __________ ______________________

Signature of patient or legal guardian Date Reviewed by

Health Questionnaire

Primary Care Physician:_____________________________________ Your Insurance I.D.#__________________________________

Address____Phone(s)____

Your Age__________ Height___________ Weight____________ Mo/Year of Your Last Medical Examination____________

HOW WOULD YOU DESCRIBE YOUR PRESENT HEALTH (CIRCLE ONE): EXCELLENT GOOD FAIR POOR DON'T KNOW

YES	NO	???	
❑	❑	❑	Has there been any change in your general health in the past year?
❑	❑	❑	Have you had a serious illness, operation or hospitalization during the past five years? If yes, please describe____
❑	❑	❑	Are you taking or recently taken any medications? If yes, **PLEASE LIST ALL** prescribed medications & inhalers: ____ ____ Over the counter, natural or herbal preparations:____
❑	❑	❑	You've taken: Aredia, Zometa, Fosamax or any other Biphosphonates thru ❑ I.V., or ❑ orally?
❑	❑	❑	Has your M.D. told you to take antibiotics prior to having any type of dental procedure?
❑	❑	❑	Are you allergic to any Medications or Drugs, Latex, Iodine?
❑	❑	❑	Have you ever had adverse reaction to any drugs, anesthetics, sedatives, narcotics, aspirin, ibuprofen (Motrin)?
❑	❑	❑	Have you ever had excessive bleeding that required special treatment?
❑	❑	❑	Have you been diagnosed as having any Immunodeficiency, Systemic Lupus, ARC or AIDS?
❑	❑	❑	Is there a history of diabetes in your family?
❑	❑	❑	Are you required, due to health, to restrict your work or activity in any way?
❑	❑	❑	Are you on a special or restricted diet of any kind? ____
❑	❑	❑	Do you use any kind of tobacco? If so, how much: ___________________ per day, week, month
❑	❑	❑	Do you use any kind of alcohol? If so, how much: ___________________ per day, week, month
❑	❑	❑	Do you have any history of substance abuse or do you currently use recreational drugs?

FOR WOMEN, CHECK ALL THAT ARE APPROPRIATE: ❑ I am pregnant ❑ I am nursing ❑ I am taking birth control pills

CHECK ALL OF THE FOLLOWING THAT YOU MAY HAVE HAD IN THE PAST OR THAT CURRENTLY APPLY TO YOU:

❑Chest pain upon exertion	❑Received blood transfusion	❑Sleep Apnea	❑Headaches
❑Shortness of breath	❑Impaired liver function	❑Asthma	❑Migraines
❑High blood pressure	❑Kidney disease	❑Bronchitis	Epilepsy
❑Low blood pressure	❑Impaired kidney function	❑Emphysema	Seizures
❑Heart valve prolapse	❑Esophygeal reflux	❑Sinus trouble	Mental health problems
❑Congenital heart lesion	❑Hiatal hernia	❑Persistent cough	
❑Rheumatic fever	❑G.I ulcers	❑Tuberculosis	Glaucoma
❑Heart murmur	❑Anorexia or bulimia		Wear contacts
❑Damaged heart valve	❑Irritable bowel syndrome	❑Joint replacement surgery	Severely impaired vision
❑Heart arrhythmia	❑Colitis	❑Arthritis	
❑Tachycardia	❑Diabetes	❑Connective tissue disorder	Recurrent infections
❑Heart surgery	❑Radiation therapy	❑Osteoporosis	Chronic fatigue
❑Cadiac pacemaker	❑Chemotherapy		Recent weight loss
❑Hepatitis or jaundice	❑History of cancer	❑Neurological disorders	
		❑Stroke	

Do you have any disease, problem or condition not listed above? Please explain:____

____

____ ___________________ ____

Signature of patient or legal guardian Date Reviewed by

PATIENT DEMOGRAPHIC INFORMATION

Mr. Mrs. Miss Ms. Dr. ____

I wish to be called at: home/ work, other______________ Name of Spouse/Partner _____________________________

Address: ____ City: _________________ St: _______ Zip Code: ________

Home Phone: (____)________________Work Phone: (___)______________________ Ext.#: ___________________

Cell: (____)________________ E-mail: ____

Date of Birth: ________________________________ Social Security #: __________-__________-__________

Emergency Contact Name: ____________________ Relationship: _______________ Phone Number: _______________

Referred by:__________________________________ Your General Dentist _____________________________

(If Different from Referral)

DENTAL INSURANCE INFORMATION

Primary Insurance

Name of insured___________________________

Relationship to Patient______________________

Insured's Date of Birth ______________________

Soc. Sec. # ___________-_______-____________

Employer__________________________________

Occupation_________________________________

Insurance Co. _____________________________

Group # __________________________________

Group Name ______________________________

Secondary Insurance

Name of Insured________________________

Relationship of Patient__________________

Insured's Date of Birth __________________

Soc. Sec. #__________-________-_________

Employer ______________________________

Occupation_____________________________

Insurance Co. __________________________

Group # _______________________________

Group Name ____________________________

______ I am not covered by any Dental Insurance at this time

I, hereby authorize *Michael Edwards DDS, MSD*, or his staff to release any and all medical and dental information pertinent to my treatment to the above named insurance carrier(s) for the purposes of pre-authorization of treatment plan and fees, claims processing, utilization review or financial audit. In addition, I hereby authorize insurance payment directly to Michael D. Edwards DDS, MSD of the medical and dental benefits otherwise payable to me, for the services rendered to me by either doctors or their staff. I have been informed that this office will report my diagnosis, treatment and fees to my carrier(s) in accord with standards conforming to the current procedures established by the American Dental Association, and that it is the sole power and responsibility of my carrier(s) to determine the actual dollar amounts of benefits for all services rendered. I understand that I am ultimately responsible for the total costs of my treatment provided by Michael D. Edwards DDS, MSD.

Privacy of Information Policy: I have been informed that this practice will make reasonable effort to protect the privacy of my health information in accord with the policies set down for dental care providers under the Health Insurance Protection and Accountability Act of 1996 and have read this practice's policy statement on privacy of patient's healthcare information. I authorize the release any and all medical and dental information pertinent to my treatment to my other treating healthcare providers.

Cancellation Policy: There will be a substantial (1/3 normal fee) charge if a surgical treatment appointment is canceled with less than 2 working days notice. All other appointments require 1 full working day's notice for any change. Please remember this time is reserved exclusively for you. Your courtesy in doing this may allow someone else to be seen in a timelier manner.

Payment: Payment is due at the time of scheduling for surgical appointments, and you will be reimbursed with any insurance coverage. We do ask for ½ of the amount of surgery 2 weeks prior to your appointment so that we may order the materials necessary for your treatment.

I acknowledge that I have read and understand the above statements and policies and that this authorization remains valid and effective from the date of signing until revoked in writing.

I give my permission for *Implant Dentistry and Periodontics*, to use close-up photographs for teaching or in any publication, either printed or electronic, including the Internet (website), published by *Implant Dentistry and Periodontics*, or any educational/dental professional publication where appropriate.

____ ________________________________

Signature of Patient or Patient's Legal Guardian Date of Signature