

THE CENTER FOR EXCEPTIONAL DENTISTRY

PATIENT INFORMATION AND MEDICAL HISTORY QUESTIONNAIRE

PATIENT INFORMATION

Name: _____ Birthdate: _____

Street Address: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Birth Date: _____ Soc. Sec. # _____

Email: _____ Spouse name: _____

Sex : M F _____ Employed yes no Student full time part time

Emergency Contact: _____ Phone _____

DENTAL INSURANCE INFORMATION

Primary Insurance Information:

First Name of Insured _____ Last Name _____ MI _____

Relationship to insured: self spouse child other

Policy/Group# _____ Insurance ID _____

Insured birth date: _____

Insurance Plan or Program Name _____

Insurance complete address _____

Insured address if different from patient: _____

Medical History: Please be as complete as possible. This questionnaire has been designed to provide Dr. Polan with important facts regarding your dental and medical health.

- I. Please list any medications or substances which have caused an allergic reaction:
 - a. Yes no Latex
 - b. Yes no Pennicillin

Other: _____

II. List any medications you are currently taking:

Medication name	Dosage/frequency	Reason

If you need more space, list here:

III. MEDICAL HISTORY

Medical condition	never	current	Past and date
Anxiety/Depression/other mental health disorders (circle what applies)			
Sensitivity in teeth			
Snoring/Sleep apnea (circle which applies)			
Jaw Pain or click (circle which applies)			
Bleeding from gums when brushing			
Injury to teeth			
Jaw Joint surgery			
Adenoids or tonsils removed(circle which applies)			
Asthma			
High Blood pressure (hypertension)			
Low blood pressure (hypotension)			
Bleeding easily			
Bruising easily			
Cancer (indicate type)			
Chemotherapy			
Chronic cough			
Heart disease, heart attack, palpitations (circle which applies)			
Heart pacemaker/valve replacement (circle which applies)			
Heart murmur			
Hepatitis C			
Poor circulation			
Sinus problems			
Hemophilia or other bleeding problems			
Prior orthodontic treatment			
TMJ discomfort			
Diabetes			

Kidney disease			
Rheumatic fever			
Angina			
Seizures			
AIDS/HIV			
Thyroid issues			
Arthritis			
Stroke			
Tuberculosis			
Glaucoma			
Liver disease			

Questions: Please answer as completely as you can.

When was your last dental visit: _____

THE FOLLOWING INFORMATION IS TOTALLY CONFIDENTIAL

Do you use any controlled substances? (please be as truthful as possible, as this is critical information that we need to know to provide proper treatment) List here: _____

Do you use tobacco in ANY form: ____ Yes ____ No if yes, what: _____

Is there any chance you may be pregnant? ____ Yes ____ No

Patient Signature: _____

Date: _____