

PATIENT QUESTIONNAIRE

Home Phone #: _____
Date: _____ Cell Phone #: _____ Social Security #: _____
Last Name: _____ First Name: _____ Middle Initial: _____ I.D. No. _____
Address: _____ City: _____ Zip: _____
Spouse's Full Name: _____ Parent's Full Name: _____
Date of Birth: ___ / ___ / ___ City of Birth: _____ Sex: M / F Marital Status: _____
Party Responsible for Payment of Account: _____
Insurance Company: _____ Insurance Number: _____
Employer: _____ Position: _____ Work Phone #: _____
Employer's Full Address: _____
Spouse's Employer: _____ Position: _____
Referred By: _____ Physician's Name: _____
Purpose of Call: _____

DENTAL HISTORY

- Yes No 1. Are you now experiencing pain or discomfort in your mouth ?
Yes No 2. Have you ever had swollen areas of the gums ?
Yes No 3. When did you last have your teeth cleaned (Date: _____)
Yes No 4. Have you ever had gum (periodontal) treatments ?
When: _____ By Whom: _____
Yes No 5. Do your gums bleed ?
Yes No 6. Have you ever noticed any loose teeth ?
Yes No 7. Have you noticed any bad mouth odors or tastes ?
Yes No 8. Have you ever had trench mouth ?
Yes No 9. Have you worn braces to straighten your teeth ?
Yes No 10. Would you be disturbed if you lost your teeth and had to wear dentures ?
Yes No 11. Are you satisfied with the appearance of your teeth ?
Yes No 12. Are you aware of clenching, or grinding your teeth together in the daytime or at night ?
Yes No 13. Do you have headaches regularly ? _____ Mornings _____ Evenings
Yes No 14. Do you frequently have pain about the ears, temples or neck ?
Yes No 15. Have you had prolonged bleeding following extractions in the past ?

RELEASE AND ASSIGNMENT

Insurance Company _____ Group Number _____ Certificate Number _____

I hereby authorize Dr. Robert L. Mandell to release to your company or its representative, any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care. I realize that I am responsible for payment of all non-insured charges.

I also authorize and request your company to pay directly to the above named doctor the amount due me in my pending claim for Dental treatment or services, by reason of such treatment or services rendered to:

Signature: _____ Address: _____

Witness: _____ Date: _____

Patient Name _____ Date _____ ID No. _____

MEDICAL HISTORY

- Yes No 1. Are you having pain or discomfort at this time ?
- Yes No 2. Do you feel very nervous about having dental treatment ?
- Yes No 3. Have you ever had a bad experience in a dental office ?
- Yes No 4. Have you been hospitalized in the last two (2) years ?
- Yes No 5. Have you been under the care of a physician in the past two (2) years ?
- Yes No 6. Have you taken any medications or drugs during the past two (2) years ?
- Yes No 7. Are you allergic to or made sick by any drugs or medications ?
- Yes No 8. Have you had any excessive bleeding requiring special treatment ?

9. Circle any of the following which you presently have or have had:

- | | | |
|--------------------------|---------------------------|--------------------------|
| Heart failure | Emphysema | AIDS |
| Heart Disease or Attack | Cough | Hepatitis A (Infectious) |
| Angina Pectoris | Tuberculosis (TB) | Hepatitis B (Serum) |
| High Blood Pressure | Asthma | Liver Disease |
| Heart Murmur | Hay Fever | Yellow Jaundice |
| Rheumatic Fever | Sinus Trouble | Blood Transfusion |
| Congenital Heart Lesions | Allergies or Hives | Drug Addiction |
| Scarlet Fever | Diabetes | Hemophilia |
| Artificial Heart Valve | Thyroid Disease | Venereal Disease |
| Heart Pacemaker | X-Ray or Cobalt Treatment | Cold Sores |
| Heart Surgery | Chemotherapy | Genital Herpes |
| Artificial Joint | Arthritis | Epilepsy or Seizures |
| Anemia | Rheumatism | Fainting or Dizzy Spells |
| Stroke | Cortisone Medicine | Nervousness |
| Kidney Trouble | Glaucoma | Psychiatric Treatment |
| Ulcers | Pain in Jaw Joints | Sickle Cell Disease |
| Bruise Easily | Smoker current/former | |

- Yes No 10. When you walk up stairs or take a walk do you ever stop because of pain in your chest, shortness of breath, or because you are very tired ?
- Yes No 11. Do your ankles swell during the day ?
- Yes No 12. Do you use more than 2 pillows when you sleep ?
- Yes No 13. Have you lost or gained more than 10 pounds in the past year ?
- Yes No 14. Do you ever wake up from sleep short of breath ?
- Yes No 15. Are you on a special diet ?
- Yes No 16. Has your medical doctor ever said you have cancer or a tumor ?
- Yes No 17. Do you have any disease, condition, or problem not listed ?
- Yes No 18. WOMEN: Are you pregnant now ?
- Yes No 19. WOMEN: Are you practicing birth control ?
- Yes No 20. WOMEN: Do you anticipate becoming pregnant ?

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the dentist at the next appointment without fail.

Date: _____ Signature of Patient, Parent, or Guardian _____