For your convenience, this form can be filled in right in your browser and printed! Just fill it out, print it, and bring it with you to our office.

We Would Like to Get to Know You Better!

Date:_____

Full Name_____ Phone (Hm) _____ (Wk) _____

Address_____ City_____ State _____ Zip_____

Email_____ Date of birth_____ Social Security #_____

Drivers License #_____ Marital status_____ Spouse's name_____

Occupation_____ Employer_____ Work Hours_____

Contact in case of emergency _____ Phone _____

When was your last dental appointment? _____ Person responsible for your dental investment_____

How did you hear about us? _____ Why did you leave your last dentist? _____

We Want to Take Care of Your Concerns and Needs First…

What are your present dental problems? _____

Do you avoid brushing any part of your mouth? ☐ Yes ☐ No

Do your gums bleed when brushing? ☐ Yes ☐ No

Are your teeth sensitive to sweets, hot/cold, or biting pressure? ☐ Yes ☐ No

I want to know about longer lasting solutions that may cost more. ☐ Yes ☐ No

Are you dissatisfied with your teeth and their appearance? ☐ Yes ☐ No

Does dental treatment make you nervous?
☐ No ☐ Slightly ☐ Moderately ☐ Very

I think my dental health is…
☐ Excellent ☐ Good ☐ Fair ☐ Poor

If I could change my smile I would make my teeth…
☐ Whiter ☐ Straighter ☐ Close Spaces ☐ Repair Chips

Other concerns/needs of mine are _____

For Insurance Purposes…

Name of policy holder_____ Policy holder Social Security # _____ - _____ - _____

Policy holder's date of birth_____ Employer_____ Name of ins. co._____

Insurance company's Phone_____ Group #_____ Ins. Co. Address_____

Are you covered by another plan? If so please complete the following…

Name of policy holder_____ Policy holder Social Security # _____

Policy holder's date of birth_____ Employer_____ Name of ins. co._____

Insurance company's Phone_____ Group #_____ Ins. Co. Address_____

Print

Morgan Hill Dental Care
HEALTH QUESTIONAIRE

OFFICE USE ONLY

Patient Name: _____ **MEDICAL ALERT: YES NO**

Sex Age Height Weight

Occupation

Marital Status

Directions

Please circle the appropriate answer to the question and fill in the blanks where indicated. Answer all questions and blanks completely. The information is for our records and will be considered confidential.

1. Are in you in good health Yes No
   a. Has there been any change in your general health? Yes No
2. My last physical examination was on _____
3. Are you now under the care of a physician? Yes No
   a. If so, what is the condition being treated?
4. The name and address of your physician is: Yes No
5. Have you ever had a serious illness or operation? Yes No
   a. If so, what?
6. Have you been hospitalized with any of the following within the last five (5) years? Yes No
   a. Do you have persistent cough or cough up blood Yes No
   b. Low blood pressure Yes No
   c. Venereal Disease Yes No
   d. AIDS or HIV+ Yes No
   e. Other Yes No
7. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma Yes No
   a. Do you bruise easily Yes No
   b. Have you ever required a blood transfusion? Yes No
   If so please explain.
8. Do you have any blood disorders such as anemia Yes No
9. Have you had surgery or x-ray for a tumor, growth or other condition of your mouth or lips
11. Are you taking any of the following: Yes No
   a. Antibiotics or sulfa drugs Yes No
   b. Anticoagulants(Blood thinners) Yes No
   c. Medicine for high blood pressure Yes No
   d. Cortisone (steroids) Yes No
   e. Tranquilizers Yes No
   f. Aspirin Yes No
   g. Insulin , Tolbutamide (Orinase)or similar drug Yes No
   h. Nitroglycerin Yes No
   i. Digitalis or drugs for heart trouble Yes No
   j. Fen-Phen (now, or in the past) or any related drugs such as Ionimin, Adipex , Phentermine, Fastin, Pondimin (Fenfluramin), and Redux(dexenfluramine) Yes No
   k. Oral contraceptives Yes No
   If so, what are you using
   l. Other

12. Do you have a heart defect or mitral valve prolapse? Yes No
13. Do you have any implants and/ or prosthesis (ie knee joints, elbow pins, etc)? Yes No
   If, so, explain
14. Do you drink alcoholic beverages? Yes No
15. Do you smoke? Yes No
   If so, how much
16. Do you have any or had any of the following disease or problems: Yes No
   a. Rheumatic fever or rheumatic heart disease? Yes No
   b. Congenital heart lesions?
   c. Cardiovascular disease (heart trouble, heart attack, coronary, occlusion, high blood pressure, arteriosclerosis, stroke) Yes No
      1. Do you have pain in the chest upon exertion Yes No
      2. Are you ever short of breath after mild exercise Yes No
      3. Do you short of breath when you lie down or do you require extra pillows when you sleep Yes No
   d. Allergy Yes No
   e. Asthma or hay fever Yes No
   f. Hives or skin rash Yes No
   g. Fainting spells or seizures Yes No
   h. Diabetes Yes No
      1. Do you have to urinate (pass water) more than six (6) times a day? Yes No
      2. Are you thirsty much of the time Yes No
      3. Does your mouth frequently become dry
   i. Hepatitis, jaundice liver disease Yes No
   j. Arthritis Yes No
   k. Inflammatory rheumatism (painful or swollen joints) Yes No
   l. Stomach ulcers Yes No
   m. Kidney trouble Yes No
   n. Tuberculosis
17. Are you allergic or have you reacted adversely to: Yes No
   a. Local anesthetic Yes No
   b. Penicillin or other antibiotics Yes No
   c. Barbiturates, sedatives, or sleeping pills Yes No
   d. Sulfa drugs Yes No
   e. Aspirin Yes No
   f. Iodine Yes No
   g. Latex Yes No
   h. Other: Yes No
18. Have you had any serious trouble associated with previous dental treatment? Yes No
   If so, explain
19. Are you pregnant or could you be? Yes No
   If so, when are you due?

I certify to the best of my knowledge that the above information is correct and that if there are any changes in the above, I agree to notify my dentist before my next visit.

Patient/ Guardian Date

Doctor Date

Updates:

Print