

Dentistry for Adults & Children
GET ACQUAINTED QUESTIONNAIRE



In order to render optimum health services, it is necessary to become acquainted with the vital information related to each patient. Of course all information is strictly confidential. Although some questions may seem unimportant at the moment, they may be vital in case of emergency.

Therefore, *PLEASE READ AND ANSWER EVERY QUESTION.*

Please feel free to ask receptionist for help in completing this form. Please **print** all information
Date: _____.

Name: _____

Home Address: _____

Telephone: _____ Postal Code: _____

Email: _____

Date of Birth: _____ Marital Status: _____

Occupation: _____

Physician: _____ Phone: _____

Whom May We Thank for Referring You to Our Office: _____

Person Responsible For Account:

- | | | |
|------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Self | <input type="checkbox"/> Government Assistance | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Insurance | | _____ |
| | | _____ |

Policy Number: _____

Emergency Contact: _____ Relation: _____

Emergency Contact Telephone: _____

HEALTH QUESTIONNAIRE (check where appropriate)

- | | YES | NO |
|--|--------------------------|--|
| Are you presently in good health? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you under the care of a physician now? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you presently taking any medications? | <input type="checkbox"/> | <input type="checkbox"/> |
| In the past 12 months, have you taken any of the following: | | |
| <input type="checkbox"/> Antibiotics/ sulphas | | <input type="checkbox"/> Anticoagulants (blood thinners) |
| <input type="checkbox"/> Medicine for high blood pressure | | <input type="checkbox"/> Antidepressants |
| <input type="checkbox"/> Insulin, Metformin, Orinase, or similar drugs | | <input type="checkbox"/> Aspirin |
| <input type="checkbox"/> Drugs for heart arrhythmias | | <input type="checkbox"/> Nitroglycerin/Nitro-patches |
| <input type="checkbox"/> Corticosteroids | | <input type="checkbox"/> Recreational Medications |
| | | <input type="checkbox"/> Biologics |
| Have you experienced undue fatigue or loss of energy recently? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has your weight changed by more than 10lbs in the last 6-12 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you on a diet? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you sleep well? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you require more than one pillow when sleeping? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you experience difficulty in keeping comfortably warm at room temperature (21°C)? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you bleed for a long time when cut? | <input type="checkbox"/> | <input type="checkbox"/> |

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Do you notice spontaneous bruising with no apparent cause?

Do you have any known seasonal or food allergies (hay fever, seafood)?.....

Do you have sensitivity or allergy to any of the following medications:

- | | |
|--|--|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Local anaesthetics |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Iodine |
| <input type="checkbox"/> Anti-inflammatories | <input type="checkbox"/> Sedatives or sleeping pills |
| <input type="checkbox"/> Opiates | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Sulphas | _____ |

Have you had any childhood diseases? (Ex. Mumps, measles)

Is so, which ones? _____

Have you ever been hospitalized or had any lengthy illness?

Please list these incidents below:

Age _____	Reasons/illnesses _____
_____	_____
_____	_____
_____	_____
_____	_____

Do you have any cardiovascular concerns? (Ex. chest pains, angina, heart attack, stroke, high blood pressure, arrhythmias, etc.)?

Have you ever experienced any difficulty breathing? (Ex. Asthma, bronchitis, COPD)

Have you ever experienced any stomach or intestinal disorders? (Ex. Gall bladder, ulcers, nausea, irritable bowel/Crohn's)

Have you ever experienced any neurological disorders? (Ex. Seizures, tremors, palsy, nervous breakdown, migraine headaches)

Have you ever had any of the following:

- | | | |
|------------------------------------|--|-----------------------------------|
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Epilepsy |

Is there a history of any heart or lung or neurological diseases, or genetic disorders in your family?

If so, please indicate: _____

Do you use any of the following? If yes, please indicate amount.

- | | |
|---|-------------|
| <input type="checkbox"/> Cigarettes/Cigars/Pipe | _____ / day |
| <input type="checkbox"/> Alcohol | _____ / day |
| <input type="checkbox"/> Sleeping Pills/Anxiolytics | _____ / day |
| <input type="checkbox"/> Recreational Medications | _____ / day |

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Have you ever been diagnosed with or required to have, any of the following? Please check all that apply.

- | | |
|--|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Hypo/Hyperglycemia |
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Migraine |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Osteoporosis Medications (Ex. Fosamax, Actonel) |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Diabetes Type 1 | <input type="checkbox"/> Radiation/Chemotherapy |
| <input type="checkbox"/> Diabetes Type 2 | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Digestive Disorders/Acid Reflux | <input type="checkbox"/> Sexually Transmitted Infection |
| <input type="checkbox"/> Drug/Alcohol Dependency | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Steroid Therapy |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Head/Neck Injury | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Thrush |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> TMJ Disorder |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Hodgkin's Disease | |

**** WOMEN ONLY****

- | | YES | NO |
|---|--------------------------|--------------------------|
| Are you taking any oral contraceptives or other hormones? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, expected date of delivery: _____ | | |

DENTAL QUESTIONNAIRE

- | | | |
|--|--------------------------|--------------------------|
| Have you been under regular care by a dentist? | <input type="checkbox"/> | <input type="checkbox"/> |
| When was your last dental visit? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had any teeth extracted? | <input type="checkbox"/> | <input type="checkbox"/> |
| Were there any complications? | <input type="checkbox"/> | <input type="checkbox"/> |
| <hr/> | | |
| Do any of your teeth ache? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do your gums bleed when you brush? <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Often <input type="checkbox"/> Always | | |
| Do you have any loose teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you anxious about going to the dentist? | <input type="checkbox"/> | <input type="checkbox"/> |

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Have you ever had any negative dental experiences?

Do you notice clicking of your joints when opening or closing your mouth?

Do you grind or clench your teeth?

Do you have a present dental concern? _____

OFFICE POLICY

Your appointment time will be reserved especially for you. If you are unable to keep the appointment, we will require **2 business days' notice**; otherwise it will be necessary to charge for the time lost. Office policy is that services are paid for at each visit as they are performed. However in certain circumstances, arrangements for payment may be made by consulting the reception.

Please indicate with a check mark:

1. I wish to pay each visit as the services are performed.
2. I wish to know the total fee for all the work to be done, as well as the number of appointments necessary, so that I can pay equal portions at each appointment.
3. I wish to discuss special arrangements for payment with the reception.

I authorize Dr. Craig R. Williams and the assistants after informed consent, to perform any dental and oral surgical procedures including the use of radiographs (X-rays) and drugs that they feel necessary for my oral health and I assume responsibility for fees associated with those procedures.

Date: _____

Signature: _____

PARENT'S CONSENT FOR CHILDREN UNDER 18

I hereby after giving informed consent to the performing of the Dental and Oral Surgery procedures necessary or advisable for my children, including the use of Local Anaesthesia and/or Relative Analgesia as indicated, accept responsibility for the fee.

Date: _____

Signature: _____