Manassas Dental House

Please fill out completely

Today's Date _____

Patient Name _____ S.S. No. _____ Birthdate _____

Residence _____ City,State _____ Zip Code _____

Home Phone _____ Cell Phone _____ E-Mail Address _____

Height _____ Weight _____ Single _____ Married _____ Occupation _____

Employer Name _____ Work Phone _____ Dental Insurance _____

Policyholder Name _____ ID Number _____ Insurance Phone Number _____

Spouse/Guardian Name _____ S.S. No. _____ Birthdate _____

Occupation _____ Employer Name _____ Work Phone _____

Referred By (We like to say "Thank You") _____ Emergency Contact: _____

GENERAL HEALTH QUESTIONNAIRE

My last physical examination was on _____

	Yes	No
Are you under the care of a physician?	☐	☐
If yes, what is the condition being treated? _____		
Have you had any serious illness or operation?	☐	☐
If yes, what was the illness or operation? _____		
Are you taking any medications?	☐	☐
If yes, what? _____		

Name and phone number of physician _____

Are you taking any of the following:

Aspirin	☐	☐
Anticoagulants/Blood Thinner	☐	☐
Antidepressants/Tranquilizers	☐	☐
Blood Pressure Medicine	☐	☐
Cortisone (steroids)	☐	☐
Heart Medications	☐	☐
Insulin	☐	☐
Nitroglycerin	☐	☐

Do you have or have you had any of the following diseases or problems:

AIDS, ARC, HIV+	☐	☐
Arthritis	☐	☐
Artificial Heart Valves	☐	☐
Asthma	☐	☐
Cancer/Chemotherapy	☐	☐
Diabetes	☐	☐
Difficulty Breathing	☐	☐
Epilepsy/Seizures	☐	☐
Excessive Bleeding or Clotting Problems	☐	☐
GI disorders/Procedures	☐	☐
Heart Disease or Attack / M.V.P.	☐	☐
Hepatitis/Liver Disease	☐	☐
High Blood Pressure	☐	☐
Kidney Disease	☐	☐
Pacemaker	☐	☐
Prosthetic Hip or Joint	☐	☐
Psychiatric Treatment	☐	☐
Rheumatic Fever/Heart Murmur	☐	☐
Sinus Problems	☐	☐
Stomach Ulcers	☐	☐
Stroke	☐	☐
Thyroid	☐	☐
Tuberculosis or other Lung Disease	☐	☐
Venereal Disease	☐	☐

Are you allergic or have you reacted adversely to:	Yes	No
Aspirin	☐	☐
Codeine or other Narcotic	☐	☐
Erythromycin	☐	☐
Latex	☐	☐
Local Anesthetics	☐	☐
Penicillin or other Antibiotics	☐	☐
Tetracycline	☐	☐

WOMEN

Do you take birth control pills?	☐	☐
Are you pregnant?	☐	☐
If yes, what is your due date? _____		

DENTAL HISTORY

When did you have your last dental exam? _____

Dentist name and address _____

_____

Have you had problems with your teeth?	☐	☐
If yes, what kind? _____	☐	☐
Are your teeth sensitive to:	☐	☐
Cold? If yes, where? _____	☐	☐
Hot? If yes, where? _____	☐	☐
Do your gums bleed easily?	☐	☐
Have you noticed any loose teeth?	☐	☐
Do you brush daily?	☐	☐
Do you floss regularly?	☐	☐
Have you ever had your teeth straightened?	☐	☐
Do you grind or clench your teeth ever?	☐	☐
Do you get oral herpes/fever blisters?	☐	☐
Do you use tobacco products? If yes, what kind?	☐	☐
Chew ___ Cigar ___ Cigarette ___ Pipe ___		
Do you have TMJ/TMD joint pain?	☐	☐
Do you use nitrous oxide or laughing gas in dental treatment?	☐	☐
Do you have any fillings that feel rough or areas where food collects?	☐	☐
If yes, where? _____		
Have you ever had or been advised to have gum/ periodontal therapy?	☐	☐
If yes, when? _____		
Are you happy with the way your smile looks?	☐	☐
If not, what would you change? _____		

_____

Patient or Guardian Signature _____ Date _____