Scott M Dubowsky DMD 12 West 22nd St., Bayonne, NJ, 07002

DENTAL/MEDICAL HISTORY QUESTIONNAIRE

NAME: MR./MISS/MRS./MS./DR.

DATE OF BIRTH (MTH/DAY/YR):_____ /_____ /_____

ADDRESS (HOME):

PHONE NUMBER:
Home:

Business:

Cell:

OCCUPATION:

Dental Insurance Information, if applicable

Primary Insurance:

Name of Policy Holder:

Date of Birth of above person:

Insurance Company:

Insurance Policy No:

Certificate I.D.:

Secondary Insurance:

Name of Policy Holder:

Date of Birth of above person:

Insurance Company:

Insurance Policy No:

Certificate I.D.:

Who referred you to our office:

Family Doctor:

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:
NAME:

Address or Telephone:

DAY TIME PHONE:

Medical Specialist, Address or Telephone:

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private. We will review the questions and explain any you do not understand. Please fill in the entire form.

1. When was your last dental visit?

2. When did you last have dental x-rays?

3. How often are your teeth cleaned in a dental office (e.g every 3 months)?

4. How often do you brush your teeth?

a. Manual or electric brush (circle one) Soft/med/hard bristles (circle one)

5. How often do you floss your teeth?

6. List any other oral hygiene measures you use: (e.g. rinses, waterpik)

7. Have you been seeing a dentist regularly? □ Yes □ No □ Not Sure/Maybe

8. Have you ever been advised to take antibiotics prior to dental work? □ Yes □ No □ Not Sure/Maybe

9. Do any of your teeth ache? □ Yes □ No □ Not Sure/Maybe

10. Do you gums bleed when you brush your teeth? □ Yes □ No □ Not Sure/Maybe

11. Do you have any pain when you chew? □ Yes □ No □ Not Sure/Maybe

12. Have you ever experienced trauma to the facial region? □ Yes □ No □ Not Sure/Maybe

13. Have you ever had orthodontic treatment? □ Yes □ No □ Not Sure/Maybe

14. Have you ever had dental implant treatment? □ Yes □ No □ Not Sure/Maybe

a. If Yes: Dentist who performed surgery and when:

15. Please list anything else not mentioned above regarding your dental history:

Medical History

1. List any medical condition you are being treated for or have been treated for in the past year:

2. When was your last medical checkup?

3. Has there been any change in your general health in the past year? □ Yes □ No □ Not Sure/Maybe
If Yes, please explain:

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind?
□ Yes □ No □ Not Sure/Maybe
If Yes, please list:

5. Do you have any allergies? □ Yes □ No □ Not Sure/Maybe
If Yes, please list:

6. Have you ever had an adverse reaction to medicines or injections? □ Yes □ No □ Not Sure/Maybe
If Yes, please explain:

7. Do you have or have ever had asthma? □ Yes □ No □ Not Sure/Maybe

8. Do have or have ever had heart or blood pressure problems? □ Yes □ No □ Not Sure/Maybe

9. Do you have or have ever had a heart murmur, mitral valve prolapse or rheumatic fever?
□ Yes □ No □ Not Sure/Maybe

10. Do you have a prosthetic or artificial joint? □ Yes □ No □ Not Sure/Maybe

11. Do you have or have ever had any conditions or therapies that affect your immune system?
(e.g. leukemia, AIDS, HIV infection, chemotherapy) □ Yes □ No □ Not Sure/Maybe

12. Do you have or have ever had hepatitis, jaundice or liver disease? □ Yes □ No □ Not Sure/Maybe

13. Do you have a bleeding problem or disorder? □ Yes □ No □ Not Sure/Maybe

14. Have you ever been hospitalized for an illness or operation? □ Yes □ No □ Not Sure/Maybe
If Yes, please explain:

15. Do you have or have ever had any of the following? Please check.

□ chest pain	□ pacemaker	□ thyroid disease	□ steroid therapy	□ seizures	□ drug/alcohol addiction
□ heart attack	□ osteoporosis	□ lung disease	□ diabetes	□ kidney disease	□ shortness of breath
□ stroke	□ arthritis	□ tuberculosis	□ stomach ulcers	□ cancer	□ prosthetic heart valve

16. Do you have or have ever had any conditions not listed above? □ Yes □ No □ Not Sure/Maybe
If Yes, please list:

17. Are there any medical conditions that run in your family?
(e.g. diabetes, cancer, heart disease) □ Yes □ No □ Not Sure/Maybe

18. Do you smoke or chew tobacco products? □ Yes □ No □ Not Sure/Maybe
If Yes, how much?

19. Are you nervous during dental treatment? □ Yes □ No □ Not Sure/Maybe

20. For women only: Are you breast-feeding or pregnant? □ Yes □ No □ Not Sure/Maybe

To the best of my knowledge, the above information is correct:

Patient/Parent/Guardian Signature Date

Dentist Signature Date