PATIENT HEALTH QUESTIONNAIRE

Lynn A. Travis, D.D.S.
Family, Cosmetic & Implant Dentistry

5225 Nesconset Hwy
Building 6, Unit #33
Port Jefferson Station, NY 11776

In our office, we are interested in developing a complete dental health program for you. In order to do this, we must know as much about you as we do about your teeth. No two people are the same; no two mouths are alike. A complete and accurate health history is essential for proper dental care. Your cooperation in accurately completing this confidential questionnaire is appreciated. Please print.

PERSONAL INFORMATION

CELL # ( ) ____________

NAME OF PATIENT ____________ HOME TELEPHONE ( ) ____________

SEX: ☐ MALE ☐ FEMALE SOCIAL SECURITY NUMBER ☐☐☐ ☐☐ ☐☐☐☐ AGE ______ DATE OF BIRTH ____________

MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED SPOUSE'S NAME ____________

ARE YOU A FULL-TIME STUDENT? ☐ YES ☐ NO SCHOOL ATTENDING ____________

PATIENT'S PRINCIPAL RESIDENCE ADDRESS ____________ APT. NO. ______

CITY ____________ STATE ______ ZIP ______

PARENTS LIVING? ☐ YES ☐ NO FATHER'S NAME ____________ MOTHER'S NAME ____________

NAME OF PERSON RESPONSIBLE FOR PAYMENT (IF DIFFERENT THAN PATIENT) ____________ RELATIONSHIP ______

ADDRESS ____________ CITY ____________ STATE ______ ZIP ______

DO YOU HAVE DEPENDENT CHILDREN? ☐ YES ☐ NO NAMES AND BIRTHDAYS ____________

WHO MAY WE THANK FOR REFERRING YOU? ____________

EMPLOYMENT

SOC. SEC. NO. ☐☐☐ ☐☐ ☐☐☐☐ CHECK APPROPRIATE BOX: ☐ PATIENT ☐ FATHER

EMPLOYER ____________

OCCUPATION ____________ YRS. THERE ______

ADDRESS ____________

BUS. TELEPHONE ( ) ____________ EXT. NO. ______

SOC. SEC. NO. ☐☐☐ ☐☐ ☐☐☐☐ CHECK APPROPRIATE BOX: ☐ SPOUSE ☐ MOTHER ☐ GUARDIAN

EMPLOYER ____________

OCCUPATION ____________ YRS. THERE ______

ADDRESS ____________

BUS. TELEPHONE ( ) ____________ EXT. NO. ______

INSURANCE COVERAGE

(PATIENT'S POLICY)

DENTAL INSURANCE: ☐ YES ☐ NO

CARRIER ____________

MAJOR MEDICAL: ☐ YES ☐ NO

CARRIER ____________

(FATHER'S POLICY)

DENTAL INSURANCE: ☐ YES ☐ NO

CARRIER ____________

MAJOR MEDICAL: ☐ YES ☐ NO

CARRIER ____________

(MOTHER'S, SPOUSE'S, OR GUARDIAN'S POLICY)

DENTAL INSURANCE: ☐ YES ☐ NO

CARRIER ____________

MAJOR MEDICAL: ☐ YES ☐ NO

CARRIER ____________

ARE YOU COVERED UNDER MORE THAN ONE POLICY? ☐ YES ☐ NO IF YES, PLEASE EXPLAIN ____________

Each Dental Insurance policy has its own benefits. To help you get the full benefit from your policy the staff will assist you in both filling out and processing the forms. You, of course, are responsible for any and all charges not paid by your dental insurance carrier.

MEDICAL HISTORY

NAME OF FAMILY PHYSICIAN ____________ TELEPHONE ( ) ____________

OFFICE ADDRESS ____________ CITY ____________ STATE ______ ZIP ______

NAME OF SPECIALIST ____________ SPECIALTY ____________ TELEPHONE ( ) ____________

OFFICE ADDRESS ____________ CITY ____________ STATE ______ ZIP ______

DATE OF LAST VISIT ____________ REASON FOR VISIT ____________

DO YOU GENERALLY FEEL GOOD? ☐ YES ☐ NO (EXPLAIN) ____________

ARE YOU CURRENTLY UNDER A PHYSICIAN'S TREATMENT? ☐ YES ☐ NO IF YES, PLEASE EXPLAIN ____________

____

DO YOU TAKE ANY MEDICATION? ☐ YES ☐ NO (EXPLAIN) ____________

DO YOU HAVE OR HAVE YOU EVER HAD AN ALLERGIC REACTION TO: ☐ PENICILLIN ☐ ERYTHROMYCIN ☐ TETRACYCLENE

☐ SULFA ☐ OTHER ANTIBIOTICS (LIST) ____________

☐ ASPIRIN ☐ CODEINE ☐ SEDATIVES ☐ BARBITUATES ☐ OTHER DRUGS (LIST) ____________

☐ LOCAL ANESTHETICS (NOVOCAINE) ☐ GENERAL ANESTHETICS

DRIVERS LIC. # ____________ MAJOR CREDIT CARD # ____________

continued...

DO YOU HAVE OR HAVE YOU EVER HAD: (PLEASE CHECK OFF)

- ☐ Heart trouble
- ☐ Rheumatic fever
- ☐ Heart murmur; Mitral valve prolapse
- ☐ Heart prosthesis (pacemaker, valve implant)
- ☐ Arteriosclerosis
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Diabetes (or family history of)
- ☐ Tuberculosis
- ☐ Emphysema
- ☐ Shortness of breath on mild exertion
- ☐ Chest pains on mild exertion
- ☐ Asthma
- ☐ Stomach or duodenal ulcer
- ☐ Liver disease
- ☐ Jaundice (yellow skin and eyes)
- ☐ Hepatitis
- ☐ Kidney disease
- ☐ Venereal disease
- ☐ Herpes
- ☐ AIDS
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Scarlet fever
- ☐ An allergic reaction
- ☐ Hives, skin rash, hay fever
- ☐ A stroke
- ☐ Anemia or other blood disorders
- ☐ Prolonged bleeding due to a slight cut
- ☐ Excessively swollen ankles
- ☐ Thyroid or parathyroid disorders
- ☐ Emotional problems or tension
- ☐ Psychiatric treatment
- ☐ Glaucoma
- ☐ Contact lenses
- ☐ Prostate disorders (if male)
- ☐ Hospitalization for illness or surgery
- ☐ Hip prothesis

ARE YOU:

- ☐ Aware of a change in your general health in the past year
- ☐ Aware of any recent weight change
- ☐ Often thirsty
- ☐ Urinating more than six times per day
- ☐ Subject to frequent headaches
- ☐ A heavy smoker (1 package or more of cigarettes per day)
- ☐ Generally a nervous person
- ☐ Often unhappy and depressed

IF FEMALE, ARE YOU NOW:

- ☐ Pregnant; How many months? ________
- ☐ Presently breast feeding

PLEASE EXPLAIN FULLY ANY "YES" ANSWERS ABOVE.

____

____

NORMAL BLOOD PRESSURE READING (/   )

DATE LAST TAKEN   /   /

(Please list any other disorders not listed above) ________

____

____

DO YOU CURRENTLY HAVE A DENTAL PROBLEM? ☐ YES (EXPLAIN) ☐ NO ________________

PREVIOUS DENTIST ________________________________

OFFICE ADDRESS ________________ CITY ________________ STATE ________ ZIP ________

TELEPHONE (   ) ________________________________

TIME SINCE LAST VISIT ________________ ARE YOU HAPPY WITH YOUR DENTAL APPEARANCE? ☐ YES ☐ NO (EXPLAIN) ________________

REASON FOR LAST VISIT ________________ REASON FOR CHANGING ________________

DO YOU TAKE ANY SPECIAL MEDICATION PRIOR TO DENTAL TREATMENT? ☐ YES ☐ NO (EXPLAIN) ________________

DO YOU TAKE FLUORIDE SUPPLEMENTS OR RINSES? ☐ YES ☐ NO   DO YOU FLOSS DAILY? ☐ YES ☐ NO   TYPE OF TOOTHBRUSH: ☐ HARD ☐ MEDIUM ☐ SOFT

WHEN WAS YOUR LAST...	6 MOS.	1 YR.	1YR.+
COMPLETE CLEANING?	☐	☐	☐
TOPICAL FLUORIDE TREATMENT?	☐	☐	☐
CHECK UP X-RAYS?	☐	☐	☐
	1 YR.	2 YRS.	2 YRS.+
COMPLETE X-RAY SERIES?	☐	☐	☐

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS? (PLEASE CHECK OFF)

- ☐ Pain on chewing (sensitive to pressure)
- ☐ Bleeding gums
- ☐ Cracked, chipped, broken teeth
- ☐ Loose or broken fillings
- ☐ Bad breath/unpleasant taste
- ☐ Swelling
- ☐ Soreness in mouth
- ☐ Jaw pains (jaw locks/clicking, popping noises)
- ☐ Oral habits (thumbsucking/nailbiting)
- ☐ Dentures (full/partial) ____________ yrs. (Age of present denture/s)
- ☐ Root canal treatment (Endodontics)
- ☐ Problems during dental surgery (bleeding, etc.)
- ☐ Extreme nervousness or apprehension
- ☐ Unfavorable dental experience
- ☐ Tooth grinding or clenching habits
- ☐ Teeth straightened orthodontically
- ☐ Gum treatment
- ☐ Missing teeth
- ☐ Spaces between teeth
- ☐ Sensitivity to hot, cold, or sweets
- ☐ Crowns or bridges ____________ yrs. (Age of present Cr/Br)

FOR OFFICE USE ONLY

RECPT. ________________

HYGENIST ________________

DOCTOR(S) ________________

SPECIALIST(S) ________________

____

This is to the best of my knowledge my health condition at the present time, and I will inform the office of any changes should they develop. I give permission to obtain my prior medical or dental records, if needed.

The investment necessary to complete dental treatment is an estimate based on information from our examination. Should additional problems arise as treatment progresses, this estimate may be revised. This estimate will be honored for a period of three months only.

I understand that I am fully responsible for payment of this account.

Balances unpaid after 30 days from date of statement are subject to a late payment charge of 1½% per month or maximum allowed by law, if different, together with expenses incidental to collection, including reasonable attorney's fees.

If there is anything else the office should know, please explain

____

____

DATE ______ / ______ / ______

SIGNATURE ________________________________

(PARENT OR GUARDIAN IF PATIENT IS A MINOR)