THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE SO THAT WE MAY SERVE YOU BETTER. PLEASE DO NOT HESITATE TO COME TO US IF YOU HAVE ANY DENTAL QUESTIONS OR CONCERNS THAT YOU WOULD LIKE TO DISCUSS WITH US.

SINCERELY,
DR. PRUSZ AND DR. VANDEVENTER

PATIENT INFORMATION (CONFIDENTIAL) DATE _____

Name _____ Birthdate _____ Soc Sec # _____
FIRST MI LAST

Nickname, Or Name You Prefer To Be Called _____ Home Phone _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

Check One Please: Minor _____ Married _____ Single _____ Widowed _____ Divorced _____ Separated _____

If A Student: Name Of School/College _____ City _____ State ____ Full Time ____ Part Time ____

Patient's (or Parent's) Employer _____ Work Phone _____ EXT _____

Occupation _____

Spouse (or Parents) Name _____ Employer _____ Work Phone _____

Person To Contact In Case Of Emergency _____ Relationship _____ Phone _____

Person Responsible For Payment Of Account _____ Relationship To You _____

Address And Phone If Different From Above _____

Person to contact **OTHER** than emergency contact above _____ Phone _____

Where May We Call You To Confirm Appts.? _____ Home _____ Work _____ Cell

DENTAL INSURANCE INFORMATION:

Name Of Subscriber _____ Relationship To Patient _____

Subscriber's Social Security # _____ Subscriber's Date of Birth _____

Name Of Employer _____ Name Of Insurance Carrier _____

Insurance Co Address _____ City _____ State _____ Zip _____

SECONDARY DENTAL INSURANCE INFORMATION:

Name Of Subscriber _____ Relationship To Patient _____

Subscriber's Social Security # _____ Subscriber's Date Of Birth _____

Name Of Employer _____ Name Of Insurance Carrier _____

Insurance Co Address _____ City _____ State _____ Zip _____

--------PLEASE TURN OVER--------

PATIENT MEDICAL HISTORY (CONFIDENTIAL)

Physician _____ Office Phone _____ Date of Last Exam_____

Are you under a physician's care now?_____

Are you taking any medications, including non-prescription medicine? If so, please list: _____

_____

_____

_____

_____

Do you use tobacco? _____

Women Only: Are you pregnant or do you think you could be pregnant? _____

Are you allergic to, or have you ever had a reaction to the following:

	YES	NO
Local Anesthetics(e.g. novocaine)	____	____
Penicillin/Amoxicillin	____	____
Sulfa Drugs	____	____
Erythromycin	____	____
Sedatives or Pain Medication	____	____
Please list if answered yes _____		
Aspirin	____	____
Codeine	____	____
Any Metals (e.g. nickel, mercury, etc.)	____	____
Latex Rubber (e.g. gloves)	____	____
Iodine	____	____
Other (please list)		

Do you take, or have ever taken, Bisphosphonates (Fosamax, Actonel) for Osteoporosis, or chemotherapy for multiple myeloma, etc)? YES _____ NO _____

Do you require Premed (antibiotics) before dental appointments? YES _____ NO _____ DO NOT KNOW _____

Do you use Nitrous Oxide (laughing gas) for dental procedures? YES _____ NO _____

IN ORDER FOR US TO TREAT YOU MOST EFFICIENTLY, HAVE YOU HAD, OR DO YOU HAVE, ANY OF THE FOLLOWING? Please <u>circle</u> all that pertain to you, or <u>add</u> other information if necessary.

MITRAL VALVE PROLAPSE
RHEUMATIC FEVER
HEART MURMUR
HEART DISEASE
HEART PROBLEMS
HEART SURGERY
ARTIFICIAL VALVES
CARDIAC PACEMAKER
HIGH BLOOD PRESSURE
LOW BLOOD PRESSURE
EPILEPSY/SEIZURES
DIABETES
ALLERGIES/HAY FEVER
SINUS CONDITION
JOINT REPLACEMENT OR IMPLANT
STOMACH PROBLEMS/ULCERS
RESPIRATORY PROBLEMS
KIDNEY PROBLEMS
ARTHRITIS
BLOOD DISORDER
THYROID PROBLEMS
OTHER MEDICAL CONDITIONS _____
(please list)
_____
ANEMIA
HEPATITIS
ASTHMA
EMPHYSEMA
TUBERCULOSIS
CANCER
HERPES
STROKE
AIDS/HIV

I certify that the above information is correct and that providing incorrect information could be dangerous to my health. I authorize the release of information including diagnosis and the records of any treatment or examination rendered to me or my child to my insurance company or health practitioner. I authorize my insurance co. to pay directly to the dentist any benefits otherwise payable to me. I understand that my ins. co. may not pay all of the dental charges. I agree to be responsible for payment of all services rendered to me or my dependents. If my account is not paid within 90 days of the date of service & no financial arrangements have been made, I agree to be responsible for legal fees, collection agency fees, interest charges.

_____ Date _____
Signature of Patient (or parent if patient is a minor)

FOR NEW PATIENTS ONLY:

How long has it been since your last dental check up? _____

How long has it been since your last dental X-rays? _____

May we contact your previous dentist for your records? _____Dentist's name _____

How often do you brush?_____ How often do you floss?_____

Reason for your visit with us today? _____

What would you like to change about your smile? _____

Are you having any dental discomfort?_____ If yes, please describe_____

Have you ever had gum surgery? _____ If yes, when and where _____