Rana Lee, D.D.S., P.A.

GENTLE DENTISTRY FOR ALL AGES

GET ACQUAINTED QUESTIONNAIRE

In order for us to serve you better, please fill in the following information. (Complete both sides).

Patients's Name_____ Date of birth_____
MARRIED SINGLE MALE FEMALE

If a Child, _____ Date of birth_____
NAME OF PERSON WHO IS RESPONSIBLE FOR THE ACCOUNT

Driver's license number__ _____ Social security number _____

Residence (Street) _____ City_____ State_____ Zip Code_____

Home Phone _____Cell Phone _____ Email_____

Emergency Contact_____Relationship_____Phone _____

Employed by _____ Present Position _____

Business Address _____ Phone _____

Name of Spouse _____Date of birth_____

Spouse Employed by _____ Present Position _____

Whom may we thank for referring you to our office? _____

HEALTH HISTORY

Circle any of the following which you have had or have at present:

HEART
heart failure
heart disease or attack
angina
pectoris
high blood pressure
rheumatic fever
congenital heart lesions
scarlet fever
artificial heart valve
pacemaker / defibrillator
heart surgery
mitral valve prolapse
ARTIFICIAL JOINT
STROKE
KIDNEY TROUBLE
ULCERS
EMPHYSEMA
TUBERCULOSIS
ASTHMA
DIABETES
THYROID DISEASE
CHEMOTHERAPY
CANCER or TUMOR HISTORY
HERPES
CORTISONE MEDICINE
(or other steroids)
GLAUCOMA
PAIN IN JAW JOINTS (TMJ)
AIDS / HIV
HEPATITIS A (infectious)
HEPATITIS B (serum)
HEPATITIS C
LIVER DISEASE
YELLOW JAUNDICE
BLOOD TRANSFUSION
DRUG ADDICTION
HEMOPHILIA
VD (syph, gon)
EPILEPSY
SEIZURES
FAINTING
DIZZY SPELLS
PSYCHIATRIC TREATMENT
DO YOU USE TOBACCO?_____

Please circle only if the answer is yes.

Yes Have you been a patient in the hospital during the past 2 years?
If yes, what for_____
Yes Have you been under the care of a medical doctor during the past 2 years?
Physician's name _____
Yes Are you currently taking any drugs or medications?
Please list _____
Yes Following injuries, medical, or dental treatment have you ever had a bleeding problem?
Yes Have you become ill or shown allergy to or been told not to take any of the following?
Please circle: Penicillin (or other antibiotic) Latex
Codeine
Novocaine or other dental anesthetic
Yes Do you have any other allergies? _____
Yes Do you have any disease, condition or problem not listed that we should know about? _____

WOMEN

Yes Are you pregnant? Due date? _____
Yes Are you taking birth control medications?

INFORMED CONSENT

I certify that the answers to the health questions are correct. Since a change of medical condition or medication can affect dental treatment, I understand the importance of and agree to notify the doctor of any changes at any subsequent appointment. I give my consent for the dental treatment that the doctor indicates on the examination chart and any other dental treatment deemed necessary or advisable as a corollary to the planned dental treatment. I also agree to the use of a local anesthetic, as needed.

If patient is a minor, I hereby grant permission for dental treatment to be performed on this minor and will assume all responsibilities connected with such treatment.

X_____ X_____
Doctor's signature Date Signature Date

SMILE EVALUATION

Is there anything about your smile you don't like? _____

Do you like the appearance of your teeth? _____

Are your teeth all in alignment (straight)? _____

Do you have any missing teeth? _____ Are any chipped? _____

Is your bite comfortable for chewing, biting? _____

Do you have frequent headaches? _____

Do you have any old fillings or dental work that you don't like? _____

What would you like to change the most in the appearance of your teeth? _____

Are you aware of the new techniques in dentistry? _____

DENTAL HISTORY

Are you nervous about dental treatment? _____

Is there anything about your mouth that concerns you now? _____

How long has it been since you have seen a dentist? _____

What type of toothbrush do you use? ☐ Soft ☐ Medium ☐ Hard

Do you use dental floss, toothpicks? _____ How often? _____

When was your last dental appointment? _____ X-rays? _____

Last date you had your teeth cleaned? _____

Do your gums ever bleed? _____ How often? _____

Are any of your teeth mobile? _____

Do you have any swelling, sores or blisters in your mouth? _____

Have you ever been instructed in how to prevent tooth decay? _____

Have you ever been told that you have gum disease? _____

Do you smoke? _____ Chew Tobacco? _____

Do you feel you have unpleasant breath at times? _____

How would you describe your dental health? _____

REMARKS

_____

_____

_____

_____

_____

Rana Lee, D.D.S., P.A.
GENTLE DENTISTRY FOR ALL AGES