WEIERBACH
PROSTHODONTICS

HEALTH QUESTIONNAIRE

Today's Date ___/___/___ Name _____ MI ____ Last Name _____ ☐M ☐F

Date of Birth ___/___/___ Name of Parent or Legal Guardian (*If Minor*) _____

Address _____ City _____ State _____ Zip _____

Home Phone (_____) _____ Cell Phone (_____) _____ Work Phone (_____) _____

Pharmacy (Complete Name) _____ Telephone Number _____

Do any of the below conditions apply to you? (Please check yes or no)

	YES	NO		YES	NO
PREMEDICATION for Dental Visits			Anemia		
High Blood Pressure/Hypertension			Bleeding Disorder/Hemophilia		
Low Blood Pressure			Kidney Disease/Renal Dialysis		
Heart Mummur			Organ Transplant		
Rheumatic Fever			Cancer (Type _____)		
Mitral Valve Prolapse (MVP)			Chemotherapy/Radiation Therapy		
Angina Pectoris/Chest pain			Epilepsy/Seizure		
Heart Attack			Stomach Ulcer		
Prosthetic (artificial) Heart Valve			Colitis/Intestinal Problems		
Irregular /Rapid Heart Beat			Osteoarthritis		
Pacemaker/Implanted Defibrilator			Rheumatoid Arthritis/Lupus		
Heart Disease/Heart Surgery/Bypass			Artificial Joints/Screws		
Stroke			Sexually Transmitted Disease (STD)		
Emphysema			AIDS/HIV		
Asthma			Tuberculosis (TB)		
Diabetes (Type _____)			Psychiatric Treatment		
Thyroid Disease / Goiter			Alcohol/Substance Abuse		
Jaundice / Liver Disease			Allergy to Latex		
Hepatitis (Type _____)			Pregnant/Nursing		
Blood Transfusion			Other (Specify _____)		

Medications/Reason_____

_____

Allergies_____

_____

Hospitalizations/Surgeries_____

_____

Any Other Additional Medical Concerns?_____

_____

DENTAL INFORMATION

	YES	NO	DK		YES	NO	DK
Do your gums bleed when you brush or floss?				Do you have earaches or neck pains?			
Are your teeth sensitive to cold, hot, sweets or pressure?				Do you have any clicking, popping or discomfort in the jaw?			
Is your mouth dry?				Do you brux or grind your teeth?			
Have you had any periodontal (gum) treatments?				Do you have sores or ulcers in your mouth?			
Have you ever had orthodontic (braces) treatment?				Do you wear dentures or partials?			
Have you had any problems associated with previous dental treatment?				Do you participate in active recreational activities?			
Is your home water supply fluoridated?				Have you ever had a serious injury to your head or mouth?			
Do you drink bottled or filtered water? If yes, how often? DAILY / WEEKLY / OCCASIONALLY				Date of your last dental exam: What was done at that time?			
Are you currently experiencing dental pain or discomfort?				Date of last dental x-rays:			
What is the reason for your dental visit today?							
How do you feel about your smile?							

PATIENT RECORD OF DISCLOSURES

I wish to be contacted in the following manner:

Home Telephone: _____ Cell Telephone: _____ Work Telephone: _____

_____ OK to leave message with detailed information

_____ Leave a voice message with a call back number only

_____ I prefer you only speak with me

Written Communication: _____ OK to mail to my home address _____ OK to mail to my work address:

_____

Persons authorized to speak with us?

Name Relationship

_____ _____

_____ _____

_____ _____

I certify that all the proceeding answers contained in this health history are complete and true I understand that responding inaccurate could be dangerous to my health and cause adverse reactions during dental treatment. I understand that I am responsible for any errors or omissions that I may have made in completion of this form. It is my responsibility to inform the clinician of any health changes prior to services being rendered. I hereby authorize Weierbach Prosthodontics to release the necessary information to secure the payment of third party benefits. I authorize the use of this signature on all insurance submissions. I agree to be responsible for payment of all services rendered if not covered by the dental insurance.

_____ _____

Patient or Legal Guardian (Signature/Print Name) Date