# Questionnaire

Name_____ Date of Birth_____

Address_____ City _____Zip_____

Home Number _____Cell _____Social Sec Number_____

Employer_____Occupation_____

Email_____ Work Number_____

Spouse_____ Work Number_____

Person Responsible for Account_____ Number_____

Relationship_____ Social Sec Number _____

How Did You Hear About Our Office? _____

DENTAL INSURANCE INFORMATION

Insurance Carrier _____ Phone number _____

Subscriber_____ Date of Birth_____

Social Sec Number_____

SECONDARY INSURANCE INFO

Insurance Carrier _____ Number_____

Subscriber_____ Date of Birth _____

Social Sec Number_____

Keep in mind that your insurance contract is between you and your insurance company. You should be familiar with the terms of the plan. Most plans do not provide full coverage. You will be responsible for ALL deductibles and charges not covered by you insurance plan at the time of service.

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS: I authorize the release of any dental information necessary to process my insurance claims and I further authorize and request my insurance to send payment directly to the dentist. SIGNATURE_____Date_____

In case of default on my account, I agree to pay late charges, collections costs and reasonable fee's incurred in attempting to collect this amount.

Signature_____Date_____

Although dental personnel primarily treats the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have had, or medications that you may be taking, could have an important interrelationship with the dentistry that you may be receiving. Your dentist is legally obligated to ask the following questions. MISSOURI LAW REQUIRES THAT YOU ANSWER THEM!

NAME_____ BIRTHDATE_____

EMAIL: _____ADDRESS:_____

PHYSICIANS NAME, PHONE: _____

NOTIFY INCASE OF EMERGENCY OTHER THAN SPOUSE_____

RELATIONSHIP_____PHONE_____

ARE YOU CURRENTLY UNDER A PHYSICIANS CARE? YES NO

HOW LONG HAS IT BEEN SINCE YOU'VE HAD YOUR TEETH CLEANED? _____

**DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS? CIRCLE ALL THAT APPLY.**

| | | | |
|---|---|---|---|
| HIGH BLOOD PRESSURE | SEIZURES | BLOOD THINNER | HEPATITIS |
| DIABETES | RHEUMATIC FEVER | JAUNDICE | ANEMIA |
| CONGENITAL HEART DISEASE/ LESIONS | KIDNEY TROUBLE/DISEASE | FAINTING | SALT RESTRICTIONS |
| HEART MURMUR | TUBERCULOSIS | ABNORMAL BLEEDING | |
| MITRAL VALVE PROLAPSE | OTHER MAJOR SURGERY | SEVERE INFECTION | OPEN HEART SURGERY |

**HAVE YOU EVER HAD A BLOOD TRANSFUSION? YES NO**

**HAVE YOU TESTED POSITIVE FOR AIDS OR ARC YES NO**

**DO YOU HAVE AN ARTIFICIAL LIMB, JOINT, HEART VALVE OR PACEMAKER? YES NO**

**WOMEN----ARE YOU PREGNANT? YES NO**

DO YOU HAVE ANY DISEASE, HANDICAP OR CONDITION NOT LISTED ABOVE?_____

ARE YOU CURRENTLY TAKING ANY PRESCRIPTION OR OVER THE COUNTER MEDICATIONS? PLEASE LIST:_____

_____

**DO YOU HAVE ANY ALLERGIES OR ADVERSE EFFECTS TOANY DRUGS, NOVACAINE, ASPIRIN, PENICILLIN OR MOUTHWASH? YES NO**

| NAME OF MEDICATIONS | REACTION EXPERIENCED |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**SIGNATURE: _____DATE:_____**

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**SIGNATURE: _____DATE:_____**

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