



WELCOME!

TO WHARTON DENTAL

HEALTH HISTORY QUESTIONNAIRE

By filling out this form, you are authorizing us to use the information below to file your insurance claims. We will keep that information in the strictest confidentiality according to federal and state laws that govern the dental profession and patient privacy. *Questionnaires that do not have sufficient information to file insurance claims will require the responsible party to make FULL payment for services at the time they are rendered.*

PATIENT's First Name: _____ Last Name: _____

Address where you get mail: _____ City/State/Zip: _____

Email Address (please print): _____

Home #: (____) _____ Work #: (____) _____ ext. _____ CELL (____) _____

Sex: M / F Married? Y / N Birthdate: ____/____/____ PATIENT's SSN#: ____/____/____

Please indicate who, if any, are covered by dental insurance - You Spouse Children

Employer: _____ Insurance Company: _____

How long have you/your child had this policy? _____ Any recent policy changes? _____

SSN# (of responsible party): ____/____/____ BIRTHDAY (of responsible party): ____/____/____

Secondary Ins? No Yes INDIVIDUAL RESPONSIBLE FOR PAYMENT: _____
(If individual is different from patient)

How did you hear about us? _____

Nearest relative/friend NOT living w/ you: _____ Phone # _____ Relationship: _____

1. Please tell us **how can we help you today?** _____
2. When was your **last visit to the dentist?** _____
3. How can we **IMPROVE** your **SMILE?** _____

4. Have you been told by a physician or previous dentist that you need to premedicate with **antibiotics** before EACH of your dental appts? No Yes Please explain _____

5. Do you **smoke?** No Yes **Dip tobacco/snuff?** No Yes - If so, **how frequently?** _____

6. Please check the box if you have noticed any of the following **symptoms:**
 Swelling Bleeding Gums Loose Teeth
 Tartar Build-Up Bad Odors Bad Taste

7. Are your teeth **sensitive** to air, hot, cold, and/or sweets? No Yes - If yes, please describe: _____

8. Do you **clench, grit, or grind** your teeth? No Yes - If yes, when: _____

**** **Please TURN PAGE OVER and complete the Health History** ****

Please CIRCLE Yes/No - whether you have had, or currently have, the following:

AIDS or HIV-Positive	Y / N	Headaches / Migraines	Y / N	Kidney disorder	Y / N
Alcohol addiction	Y / N	HEART Problems	Y / N	Liver Disease	Y / N
Anemia	Y / N	(Please <u>circle</u> below)		Lupus	Y / N
Arthritis	Y / N	Artificial heart valves		Mental Health Disorder:	Y / N
Asthma	Y / N	Congenital heart defects		Specify: _____	
Bleeding Disorder	Y / N	Heart attack		Pregnant now?	Y / N
Blood Transfusions	Y / N	Angina (chest pain)		(# of months): _____	
Cancer: type _____	Y / N	Heart murmur		Nursing right now?	Y / N
Chemotherapy or Radiation		Mitral valve prolapse		Respiratory Problem:	Y / N
Treatment	Y / N	Pacemaker		Specify: _____	
Diabetes: Type II	Y / N	Rheumatic heart disease		Sexually-transmitted Disease: Y/N	
Type I (insulin)	Y / N	Stroke or TIA		Specify: _____	
Drug addiction: which drug?		Other: _____		Sinus Problem	Y / N
_____	Y / N	Hepatitis: type: _____	Y / N	Stomach Problem	Y / N
Emphysema	Y / N	High Blood Pressure	Y / N	Specify: _____	
Epilepsy/Seizures	Y / N	Low Blood Pressure	Y / N	Thyroid Problem:	Y / N
Fainting Spells	Y / N	Implants: _____	Y / N	Specify: _____	
Fen/Phen diet drug	Y / N	Hip/Joints, Breast, Penile, etc		Tuberculosis	Y / N
Glaucoma	Y / N	Screws & Metal Plates	Y / N	Ulcers	Y / N

Please describe **any other condition** you have that is not listed above, any **serious hospitalizations**:

Please list ALL **MEDICATIONS** that you are currently taking and the **reason why**: _____

Please list any **ALLERGIES** you may have (to LATEX, anesthetics, epinephrine, pain pills, antibiotics, etc):

Please write your **physician's name** and **phone** number below. Thank you.

Name _____ City: _____ Phone: (____) _____

By signing below, I certify that all the above information is correct to the best of my knowledge AND I understand that I am responsible for payment of all dental services rendered. If I have insurance, I will be responsible for whatever costs my insurance will not cover. Also, I understand that there is a \$30 charge for missed appointments.

(Please sign your name only once. The other signatures are for future updates to this form)

SIGNATURE: _____	DATE: _____
SIGNATURE: _____	UPDATE: _____
SIGNATURE: _____	UPDATE: _____
SIGNATURE: _____	UPDATE: _____