

Patient Questionnaire

Name: _____ Preferred Name (Nick Name): _____

Phone Numbers: Home # _____ Work # _____ Cell # _____

Address: _____ ZIP _____

Email Address: _____ **Insurance Co.** _____

1. Do you have now, OR have you ever had any of the following: (PLEASE CIRCLE YES OR NO)

High / Low Blood Pressure	Y	N	Heart Murmur	Y	N	Respiratory Therapy	Y	N	
Osteoporosis	Y	N	Angina	Y	N	Mitral Valve Prolapse	Y	N	
Hay Fever	Y	N	Cardiac Pacemaker	Y	N	Hemophilia	Y	N	
Diabetes	Y	N	Cancer	Y	N	Kidney Disease	Y	N	
Rheumatic Fever	Y	N	Arthritis	Y	N	AIDS/HIV	Y	N	
Fainting	Y	N	Anemia	Y	N	Thyroid Problems	Y	N	
Asthma	Y	N	Sexually Transmitted Disease	Y	N	Chest Pain	Y	N	
Leukemia	Y	N	Liver Disease	Y	N	Joint Replacement	Y	N	
Stroke	Y	N	Jaundice	Y	N	*If yes, when was it done? _____			
Heart Disease	Y	N	Tuberculosis	Y	N	Hepatitis	Y	N	
Epilepsy	Y	N	Radiation Therapy	Y	N	*If yes, what type? (circle one)	A	B	C

2. When was your last dental cleaning? _____

3. Are you presently under the care of a physician? YES / NO If yes, please explain: _____

Physician's Name: _____ Phone # _____

4. Have you ever been told that you needed to premedicate with antibiotics prior to dental treatment due to a heart murmur, joint replacement, and/or any other medical condition? YES / NO

** If yes, please explain: _____

5. For women only: Are you pregnant? YES / NO If yes, please give due date: _____

6. Do you have any of the following: ___ Persistent cough ___ Bloody Sputum ___ Night Sweats
 ___ Excessive Weight Loss ___ Fever

7. Are you taking any medication at the present time? YES / NO (Use a separate sheet of paper if needed)
 If yes, please list: _____

8. Do you use tobacco products? If so, how much? _____

9. Are you allergic to or have you had any reactions to any of the following: (PLEASE CIRCLE YES OR NO)

Local Anesthetics	Y	N	Iodine	Y	N
Penicillin	Y	N	Aspirin	Y	N
Barbiturates	Y	N	Any Metals (nickel, mercury, etc.)	Y	N
Sulfa Drugs	Y	N	Latex Rubber	Y	N
Sedatives	Y	N	Codeine	Y	N
Other antibiotic not listed above:					
Any other allergies/sensitivities not listed above:					

- I understand that my dental insurance will be filed and I am responsible to pay my estimated portion when services are rendered. I understand that I am responsible for all charges not covered by insurance.
- I understand that a finance charge of 1.5% per month (annual percentage rate of 18%) will be applied to all accounts not paid within 30 days of the billing date.
- I have filled this form out to the best of my knowledge. I understand that if I have not disclosed my medical history truthfully and completely, Dr. Garrett's office cannot be held responsible for any adverse consequences that may result.

Signed: _____ **Date:** _____

Doctor's Signature: _____ **Date:** _____

Please initial below at subsequent visits upon reviewing this form for updates/revisions.

Date	Initials	Changes (Please ask for another sheet if more room is needed)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____