Dental Questionnaire

RUSSELL B. RAINEY
DMD™
We Take Time to Listen™

Today's Date: ______________________

Chart # ______________________

PATIENT INFORMATION

☐ Mr. ☐ Ms. ☐ Miss ☐ Mrs. ☐ Dr. ☐ Male ☐ Female

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Name ______________________

Address ______________________

City ______________________ State ____________ Zip ____________

Home Phone: ______________________ Cell Phone: ______________________

Work Phone: ______________________ Email ______________________

Date of Birth ____________ Age ____________ Social Security # ____________

RESPONSIBLE PARTY

If Other than Patient

Relationship to Patient ______________________

Name ______________________

Address ______________________

City ______________________ State ____________ Zip ____________

Phone ______________________ SS# ______________________

Date of Birth ______________________ Age ______________________

EMPLOYMENT INFORMATION

Employer ______________________ Occupation ______________________

INSURANCE

Insurance Company ______________________ Insured's Name ______________________

Address ______________________ Insured's Group Plan ______________________

City/State/Zip ______________________ Group # ______________________

Phone ______________________ Insured's ID # ______________________

Insured's Birthday ______________________

Who can we thank for referring you to our Practice? ______________________

Please Check All Dental Concerns That Apply To You:

TEETH:

☐ Broken or Chipped	☐ Loose or Missing Filling
☐ Crooked	☐ Loose Tooth or Teeth
☐ Decay	☐ Missing Tooth or Teeth
☐ Difficulty Chewing	☐ Mouth Sores
☐ Discolored	☐ Sensitive to Temperature Change
☐ Food Trap Areas	☐ Sensitive to Sweets
☐ Grinding or Clenching	☐ Tooth Pain
☐ Any Teeth Removed	☐ Braces
Do you have Tooth Replacements such as:	When?___________________________
☐ Dentures ☐ Partials ☐ Bridges	How Long?____________________
☐ Implants ☐ Other	Do you wear a night guard? ☐ Yes

GUMS	PAST DENTAL HISTORY
☐ Bleeding	Last Dental Visit_________________________
☐ Pimple or Bump	Services at Last Visit______________________
☐ Sore or Sensitive	____
☐ Unpleasant Taste or Odor	Frequency of Previous Visits
☐ Previous gum (periodontal) Treatment	☐ ___________ Months ☐ _________ Years
	☐ ___________ As Needed

JAW / FACIAL PAIN PROBLEMS

☐ Facial Pain	☐ Jaw Pain
☐ Frequent Headaches	☐ Pain in Cheeks or Temples
☐ Jaw Clicks	☐ Limited Opening
☐ Ringing in Ears	☐ Hearing Loss
☐ Sleep Breathing Disorders	Previous Injury to:
☐ Heavy Snoring	☐ Face ☐ Neck ☐ Mouth ☐ Teeth
☐ Heavy Snoring	Are injuries a result of an accident? ☐ Yes
☐ CPAP User	If so, please describe:

Concerns or reason for today's visit

____

____

Has fear of discomfort kept you from the dentist? ______________________________

____

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Which of the following have caused an allergic reaction:

☐ Yes Antibiotics	☐ Yes Local Anesthetics	☐ Yes Sedatives
☐ Yes Aspirin	☐ Yes Metals	☐ Yes Sleeping Pills
☐ Yes Codeine	☐ Yes Novocaine	☐ Yes Sulfa Drugs
☐ Yes Iodine	☐ Yes Penicillin	Other Allergens:
☐ Yes Latex	☐ Yes Plastic	
☐ Yes Ibuprofen	☐ Yes Antibiotic	

List any medications you are currently taking:

☐ Yes Antibiotics	☐ Yes Codeine	☐ Yes Insulin
☐ Yes Anticoagulants	☐ Yes Cortisone	☐ Yes Muscle relaxants
☐ Yes Blood Thinners	☐ Yes Diet Pills	☐ Yes Pain Medication
☐ Yes Blood Pressure	☐ Yes Digestive Aids	☐ Yes Sleeping Pills
☐ Yes Cholesterol	☐ Yes Heart Medicine	☐ Yes Thyroid
		☐ Yes Tranquilizers

Please list names of all medications you are currently taking: ______________________________

____

____

MEDICAL HISTORY

☐ Yes Anemia	☐ Yes Digestive Problems	☐ Yes Kidney Problems
☐ Yes Anxiety	☐ Yes Dizziness	☐ Yes Liver Problems
☐ Yes Arthritis	☐ Yes Epilepsy or Seizures	☐ Yes Low Blood Pressure
☐ Yes Artificial Joint/Prosthetic	☐ Yes Headaches	☐ Yes Osteoporosis
☐ Yes Asthma	☐ Yes Heart Murmur	☐ Yes Radiation Treatment
☐ Yes Bleeding Easily after cut	☐ Yes Heart Pacemaker	☐ Yes Respiratory Problems
☐ Yes Cancer	☐ Yes Heart Palpitations	☐ Yes Rheumatic Fever
☐ Yes Chemotherapy	☐ Yes Heart Valve Replace	☐ Yes Scarlet Fever
☐ Yes Chronic Mouth Dryness	☐ Yes Heart Valves Damaged	☐ Yes Sinus Problems
☐ Yes Current Pregnancy	☐ Yes Hepatitis	☐ Yes Smoker
☐ Yes Depression	☐ Yes High Blood Pressure	☐ Yes Thyroid
☐ Yes Diabetes	☐ Yes Immune System Disorder	☐ Yes Tuberculosis

Other medical history that will assist us with providing optimum dental care?

____

____

____

Describe any serious illness, major surgery or conditions not listed above:

Date Description

____________ ____

____________ ____

Are You Under A Physicians Care?

Practitioner Specialty Treatment & Approximate Date

____

____

____

Primary Care Physician ______________________________________

I authorize the release of a full report of examination findings, diagnosis, treatment program, etc., to any referring or treating dentist or physician. ____________ *Patient Initials*

I understand that I am responsible for all fees for treatment regardless of insurance coverage.
____________ *Patient Initials*

NOTICE OF PRIVACY PRACTICE

As a patient, I am entitled to privacy regarding my protected health information under the Health Insurance Portability and Accountability Act (HIPAA).

The Health Insurance Portability and Accountability Act (HIPAA) requires all health plans, including ERISA, health care clearinghouses and any dentist who transmits health information in an electronic transaction, to use a standard format. Those plans and providers that choose not to use the electronic standards can use a clearinghouse to comply with the requirement. Providers' paper transactions are not subject to this requirement.

My signature confirms that I have been informed of my rights as stated above. I understand that I am entitled to a printed copy of Notice of Privacy Practices upon my request. __________ Patient Initials

Patient Signature ____________________________________ Date ____________

Patient Name ____

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