

ANES

# GENERAL INFORMATION AND HEALTH QUESTIONNAIRE

## Keith Valachi, D.D.S.—Family Dentistry

MED ALERT:

Name \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_ Home Phone \_\_\_\_\_

Responsible Party's Name \_\_\_\_\_ SS # \_\_\_\_\_ Relationship \_\_\_\_\_

Responsible Party's Address \_\_\_\_\_  
Street City State Zip Own or Rent

Responsible Party's Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Business Phone \_\_\_\_\_

Business Address \_\_\_\_\_ How Long Employed \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Employer \_\_\_\_\_

Children \_\_\_\_\_

Name of Bank and Branch \_\_\_\_\_ Driver's License and State \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_ How did you find out about us? \_\_\_\_\_

### DENTAL INSURANCE INFORMATION

Insured's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Insurance Co. \_\_\_\_\_

Insured's Address \_\_\_\_\_ Insured's Employer \_\_\_\_\_

Insured's Soc. Sec. # \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_

If you have dual Insurance Coverage:

Insured's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Insurance Co. \_\_\_\_\_

Insured's Address \_\_\_\_\_ Insured's Employer \_\_\_\_\_

Insured's Soc. Sec. # \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_

I release any information needed and assign benefits to the undersigned dentist \_\_\_\_\_ Name and Address of Physician \_\_\_\_\_

X \_\_\_\_\_ Date \_\_\_\_\_ Phone \_\_\_\_\_

### DENTAL HEALTH

Dental Reason for coming to our office: e.g. pain, cleaning \_\_\_\_\_

Name of last dentist \_\_\_\_\_ Date of last dental treatment \_\_\_\_\_ Reason for change \_\_\_\_\_

Have you ever had any serious problem associated with previous dental treatment: No  Yes  If yes, what \_\_\_\_\_

Are you apprehensive of dental treatment? Yes  No  Do you clench or grind your jaws while sleeping

Do your gums bleed while brushing or flossing Yes  No  or during the day? Yes  No

Do you avoid brushing any part of your mouth because of pain? Yes  No  Have you ever worn a partial or removable bridge? Yes  No

Do your gums feel tender or swollen? Yes  No  Do you have problems eating? Yes  No

Do you like your smile? If not, why? Yes  No  Do you have frequent headaches or

Does your jaw pop or click? Yes  No  sore neck and jaw muscles? Yes  No

Do you floss? Yes  No  How often \_\_\_\_\_

Are you happy with the appearance of your teeth? Yes  No

### MEDICAL HEALTH

General Health (please check) Excellent  Good  Fair  Poor

Have you ever had or been treated for: (please check if yes)

Heart disease/attack  Jaundice  Fainting Spells

Heart murmur  Asthma or Hay Fever  Glaucoma

Congenital heart lesions  Sinus trouble  Tumor or malignancy

Rheumatic fever  Hepatitis  Are you subject to prolonged bleeding?

High/low blood pressure  Venereal Disease  Do you have excessive urination and/or thirst?

Ulcers  Arthritis/Rheumatism  Have you ever been treated (other than diagnostic) with x-ray?

Stomach problems  Artificial joints/prostheses  Do you normally take an antibiotic prior to dental treatment?

Tuberculosis or lung disease  Are you allergic to any medications or anesthetics? If so, what? \_\_\_\_\_  Are you presently taking any medication?

Kidney/Liver problems? \_\_\_\_\_

Diabetes \_\_\_\_\_

Epilepsy/seizures \_\_\_\_\_

Anemia/blood disorders  Heart valves/pacemaker \_\_\_\_\_

Any infectious diseases  Angina \_\_\_\_\_

Thyroid problems  Cortisone use \_\_\_\_\_

(Women) Are You Pregnant?  Yes  No  If yes, due date \_\_\_\_\_ Do you use smokeless tobacco Yes  No

Any Past Surgeries \_\_\_\_\_ Do you smoke? Yes  No  How much? \_\_\_\_\_

Any other health problems we should know about: \_\_\_\_\_

Signature \_\_\_\_\_ Parent's Signature, if minor \_\_\_\_\_ Date \_\_\_\_\_

Comments

BP:

P:

Meds: