CRAIG J. THOMAS, D.D.S. HEALTH QUESTIONNAIRE

Thank you for choosing us as your dental provider. In order for us to best serve your needs, please circle yes or no, whichever applies, in response to the following questions, and fill in the blanks, where necessary. Your answers are for our records only and will be considered confidential.

Patient Name: _____ **Nickname**:_____ **Birthdate**:_____
Whom may we thank for referring you? _____

Dental History

Do you have any present dental problems? .....Yes No
Describe: _____
Do you have concerns about the appearance of your teeth?.....Yes No
Describe: _____
When was your last dental exam?_____
Is there fluoride in your drinking water? ……. Yes No

Do you have, or have you had any of the following?

1. Bleeding gums/Periodontal Disease ..... Yes No
2. Orthodontic treatment..... Yes No
3. Clicking/Pain in jaw joint ..... Yes No

Are you nervous about dental treatment? No Slightly Moderate Extremely
Describe: _____

Medical History

Physician: _____ Phone: _____
Date of last physical exam:_____
Are you in good health?.....Yes No .....Explain _____
Do you have an existing illness?.....Yes No.....Explain _____
Have you been hospitalized in the past 2 years?.....Yes No.....Explain _____
Are you or have you received bisphosphonate therapy?
Fosamax, Actonel, Boniva, Aredia or Zometa?.....Yes No
Do you need to take antibiotic premedication for dental treatment?.....Yes No

_____
Are you taking any medications?.....Yes No.....List _____
_____
_____
Whom should we notify in case of an emergency?
Name _____ Relationship:_____ Phone: _____

Do you have, or have you had any of the following?

1. Heart Disease……Yes No
2. High Blood Pressure……Yes No
3. Blood Disease……...Yes No
4. Diabetes……Yes No
5. Epilepsy……Yes No
6. Tumor History……...Yes No
7. Bleeding Problems/Excessive Bleeding……Yes No
8. Artificial Joint/Heart Valve/Pacemaker……Yes No
9. Radiation Treatment/Chemotherapy…… …Yes No
10. Liver Disease…….....Yes No
11. Kidney Disease……...Yes No
12. Thyroid Disease……..Yes No
13. Hepatitis…….....Yes No
14. Asthma……Yes No
15. Immune Deficiency Disease……Yes No
16. Allergy or Sensitivity to:
    (a) Penicillin……Yes No
    (b) Local Anesthetic……Yes No
    (c) Other Antibiotics……....Yes No
    (d) Other……Yes No
17. Do you use tobacco products?.....Yes No
18. Are you Pregnant/Nursing?.....Yes No

Do you have any other medical/dental concerns that you think we should know about? .....Yes No
Describe: _____
_____

PERSON RESPONSIBLE FOR ACCOUNT

Last Name _____First Name_____MI____Email_____

Mailing Address_____

City _____ State _____ Zip_____

Home phone _____Work phone _____Cell Phone_____

Social Security No. _____ Date of Birth _____

Employer _____ Employer Address _____

City _____ State _____ Zip _____

Do you have dental insurance? Yes No

Dental Insurance Co._____
Group No _____ Subscriber ID#. _____

SPOUSE OR SECONDARY INSURANCE INFORMATION

Last Name _____First Name_____Email_____

Mailing Address _____

City _____State _____ Zip _____

Home phone _____ Work phone _____Cell Phone_____

Social Security No. _____ Date of Birth _____

Employer _____ Employer Address _____

Dental Insurance Co. (If different than above) _____
Group No _____ Subscriber ID# _____

DEPENDENTS: (If patients at this office)

Name (First Last MI)	Birthdate
_____	_____
_____	_____
_____	_____

In case of insurance, I authorize payment to dental benefits to the provider for professional services rendered. I also authorize release of information relative to insurance claims. I assume full financial responsibility for any treatment or consultation rendered. Payment is expected at the time of service. If there is insurance, I agree to pay my deductible and the portion of the fee not covered by insurance at the time of service. I understand that if I fail my appointment or cancel without giving 24-hour notice, I may be charged $25. To the best of my knowledge, all of the preceding answers are true. If I have any changes in my health/medications, I will inform the dentist.

Signature: _____ Date: _____