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 or TMJ……..Yes No
4. 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 wheelchair dependent?.....Yes No……Can you transfer yourself? Yes No

CURRENT MEDICATIONS (If you carry a list, we will photocopy)_____

_____

_____

Whom should we notify in case of an emergency?
Name _____ Relationship:_____ Phone: _____

DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING:

Asthma	Yes	No	Hearing Impairment	Yes	No
Anxiety	Yes	No	Hepatitis/Jaundice/Liver Disease	Yes	No
Alzheimer's/Dementia	Yes	No	Immune Deficiency	Yes	No
Artificial Joint/Heart Valve/Pacemaker	Yes	No	Kidney Disease	Yes	No
Arthritis	Yes	No	Pregnant/Nursing	Yes	No
Allergy or Sensitivity to: Latex/Antibiotic	Yes	No	Radiation Treatment/Chemotherapy	Yes	No
Local Anesthetic/Medication	Yes	No	Sinus Problems	Yes	No
Blood Disease	Yes	No	Sleep Apnea	Yes	No
Bleeding Problems/Excessive Bleeding/Anemia	Yes	No	Stomach Trouble	Yes	No
Diabetes	Yes	No	Stroke	Yes	No
Depression/Psychiatric Treatment	Yes	No	Smoker/Tobacco Use	Yes	No
Epilepsy/Seizures/Fainting	Yes	No	If yes, packs or pouches per day		
Eating Disorders	Yes	No	Tumor History	Yes	No
Glaucoma	Yes	No	Thyroid Disease	Yes	No
Heart Trouble/Heart Attack/Chest Pain	Yes	No	Tuberculosis	Yes	No
High Blood Pressure	Yes	No	Weight		

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

PERSON RESPONSIBLE FOR THE 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: _____