MADISON DENTAL ASSOCIATES
HEALTH QUESTIONNAIRE

DATE_____

PATIENT'S NAME (Last, First, M.I.)_____ SEX M ( ) F( ) AGE_____

BIRTHDATE_____ SINGLE ( ) MARRIED ( ) DIVORCED ( ) WIDOWED ( ) SEPARATED ( )

HOME ADDRESS_____CITY_____STATE_____ZIP_____

HOME PHONE_____ WORK PHONE_____ CELL_____

OCCUPATION_____ SOC. SEC. # _____

INSURED'S NAME_____ RELATIONSHIP TO PATIENT_____

INSURED'S BIRTHDATE_____ SOC SEC. #_____EMPLOYER_____

INSURANCE CO._____INS. ADDRESS_____ GROUP #_____

SECONDARY INSURANCE _____

IF PATIENT IS A STUDENT, NAME OF SCHOOL_____ CITY _____ STATE_____

PERSON TO CONTACT IN CASE OF EMERGENCY_____PHONE_____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PHYSICIAN_____PHONE #_____LAST PHYSICAL_____

ARE YOU IN GOOD HEALTH?_____ IF NO, EXPLAIN _____

HAVE YOU BEEN HOSPITALIZED IN THE PAST 2 YEARS? _____FOR WHAT_____

LIST ALL MEDICATIONS INCLUDING NON PRESCRIPTION MEDS AND REASON FOR TAKING_____

_____

DO YOU USE TOBACCO?_____ ALCOHOL_____COCAINE_____OTHER DRUGS_____

CIRCLE ALL CONDITIONS WHICH YOU HAVE OR HAVE HAD:

HEART DISEASE	HIGH BLOOD PRESSURE	HEART ATTACK	STROKE
FEN FEN HISTORY	ARTIFICIAL HEART VALVES	HEART MURMUR	RHEUMATIC FEVER
ANGINA	JOINT REPLACEMENT	ARTHRITIS	EPILEPSY
DIABETES	ASTHMA	NASAL POLYPS	HEPATITIS
TUBERCULOSIS	CLOTTING DISORDERS	LIVER DISEASE	KIDNEY DISEASE
TUMOR HISTORY	RADIATION THERAPY	NERVOUS DISORDERS	VD
AIDS/HIV POSITIVE	BULEMIA/ANOREXIA		

ARE YOU PREGNANT? YES ( ) NO ( )

ARE YOU ALLERGIC TO: LOCAL ANESTHETIC ( ) BENZOCAINE ( ) PENICILLIN ( )

OTHER ANTIBIOTIC ( ) _____

LATEX ( ) ACRYLIC ( ) METALS ( )

OTHER ( ) _____

(over please)

DENTAL QUESTIONNAIRE

REASON FOR TODAY'S VISIT: _____

WHEN WAS YOUR LAST DENTAL VISIT? _____

HAVE YOU HAD ANY SERIOUS PROBLEMS WITH PRIOR DENTAL TREATMENT? _____

_____

DO YOUR GUMS BLEED WHILE BRUSHING? _____HOW OFTEN DO YOU BRUSH? _____

DO YOUR GUMS BLEED WHEN FLOSSING? _____HOW OFTEN DO YOU FLOSS? _____

HAVE YOU EVER BEEN INSTRUCTED IN THE CARE OF YOUR TEETH AND GUMS? _____

DO YOU AVOID BRUSHING ANY PART OF YOUR MOUTH?_____

DO YOU HAVE ANY UNHEALED INJURIES OR INFLAMMED AREAS IN OR AROUND YOUR MOUTH?_____

DO YOU HAVE ANY PAIN IN YOUR JAW OR NEAR YOUR EARS?_____

DO YOU CLENCH OR GRIND YOUR TEETH DURING THE DAY OR NIGHT?_____

DO ANY OF YOUR TEETH HURT FROM COLD, SWEET OR HOT FOODS?_____

DO YOU OFTEN HAVE A BAD TASTE IN YOUR MOUTH OR MOUTH ODOR?_____

WOULD YOU BE MORE COMFORTABLE HAVING NITROUS OXIDE (LAUGHING GAS) DURING TREATMENT?_____

DO YOU LIKE THE APPEARANCE OF YOUR TEETH? YOUR SMILE? _____

DO YOU LIKE THE COLOR OF YOUR TEETH?_____

ARE THERE OLD FILLINGS, DENTAL WORK OR SPACES BETWEEN YOUR TEETH THAT YOU DON'T LIKE LOOKING AT? _____

_____

I HEARBY AUTHORIZE MADISON DENTAL ASSOCIATES TO PROVIDE ANY INSURANCE COMPANY, CLAIM ADMINISTRATORS AND CONSULTING HEALTH CARE PROFESSIONALS, INFORMATION CONCERNING HEALTH CARE ADVICE AND TREATMENT. THIS INFORMATION WILL BE USED EXCLUSIVELY FOR THE PURPOSE OF EVALUATING AND ADMINISTERING CLAIMS FOR BENEFITS.

I HEARBY AUTHORIZE THE PAYMENT OF DENTAL BENEFITS OTHERWISE PAYABLE TO ME DIRECTLY TO MADISON DENTAL ASSOCIATES. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT NOT PAID FOR BY MY INSURANCE.

_____ _____

PATIENT OR AUTHORIZED GUARDIAN'S SIGNATURE **DATE**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices

_____ _____

PATIENT OR AUTHORIZED GUARDIAN'S SIGNATURE **DATE**

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

( ) Individual refused to sign ( ) Communications barriers prohibited obtaining the acknowledgement

( ) An emergency situation prevented us from obtaining acknowledgement ( ) Other _____