

Confidential Information Questionnaire

Please Print

Client's Name	Last	First	Middle	I Prefer to be Called	
Client's Address			Postal Code	Date of Birth MM/DD/YYYY	Sex
Marital Status <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> Under Age 18		Client's / Guardian's Employer		Occupation	
Home Phone	Work Phone	Cell Phone		E-Mail Address	

Please Circle Your Preferred Way of Communication Above

Children (Name(s) and Age(s))						
Specific Interests or Hobbies						
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 40%;">Person We Can Contact in Case of an Emergency</td> <td style="width: 20%;">Work Phone</td> <td style="width: 40%;">Home Phone</td> </tr> <tr> <td>Name</td> <td>Relationship</td> <td></td> </tr> </table>	Person We Can Contact in Case of an Emergency	Work Phone	Home Phone	Name	Relationship	
Person We Can Contact in Case of an Emergency	Work Phone	Home Phone				
Name	Relationship					
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Other Family Members That Are Clients Here</td> <td style="width: 50%;">Who Can We Thank For Referring You?</td> </tr> <tr> <td style="height: 40px;"></td> <td style="height: 40px;"></td> </tr> </table>	Other Family Members That Are Clients Here	Who Can We Thank For Referring You?				
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Insurance Information

(Primary) Name of Insured	Date of Birth MM/DD/YYYY	Relationship
Name of Insurance Company	Group #	ID / Certificate #
(Secondary) Name of Insured	Date of Birth MM/DD/YYYY	Relationship
Name of Insurance Company	Group #	ID / Certificate #

I understand that all the information I provided today is correct to the best of my knowledge. I understand it will be held in strict confidence and only be used to improve communication between this office, myself, and other dental specialists if required. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered and authorize my dental office to submit my claims electronically on my behalf.

Signature of client, parent or guardian _____ **Date** _____

I authorize Dr. Wasik and his team to use any records (including photographs) for lecturing/professional presentations, as well as promoting dental health to others.

Signature of client, parent or guardian _____ **Date** _____

Medical History

Client Name _____ Date of Birth _____

Name of Physician _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? Poor _____ Fair _____ Good _____

HAVE YOU EVER HAD THE FOLLOWING:		YES	NO			YES	NO
1. hospitalization for illness or injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	24. stomach or duodenal ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. allergic reaction to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	25. digestive disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> aspirin, ibuprofen, acetaminophen				26. arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> penicillin				27. glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> erythromycin				28. contact lenses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> tetracycline				29. head or neck injuries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> codeine				30. epilepsy, convulsions (seizures)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> local anesthetic				31. viral infections and cold sores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> fluoride				32. any lumps or swelling in the mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> metals (gold, stainless steel)				33. hives, skin rash, hay fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> latex				34. venereal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> any other medications _____				35. hepatitis (type _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. heart problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	36. HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	37. tumor, abnormal growth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	38. radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	39. chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	40. emotional problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	41. psychiatric treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. a stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	42. antidepressant medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. artificial prosthesis (e.g. joints / heart valve) ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	43. alcohol / drug dependency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. anemia or other blood disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
12. prolonged bleeding due to a slight cut	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
13. emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU:			
14. tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	44. presently being treated for any illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	45. aware of a change in your general health ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	46. often exhausted or fatigued	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	47. subject to frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	48. a heavy smoker (1 pack or more a day)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	49. often unhappy or depressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. thyroid or parathyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	50. easily upset or irritated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. hormone deficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	51. FEMALE - taking birth control pills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. high cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	52. FEMALE - pregnant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	53. MALE - prostate disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please describe any current medical treatment, impending surgery, or other treatment that may possible affect your dental treatment _____

List any medications, herbal supplements, and or vitamins taken within the last two years _____

**PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY
OR ANY MEDICATIONS YOU MAY BE TAKING.**

Client's Signature _____ Date _____

Doctor's Signature _____

Dental History

Referred by _____

Previous dentist _____ How long _____

Most recent dental exam _____ Most recent dental x-ray _____

Most recent dental treatment _____

How often do you have your teeth cleaned? 3 mo. _____ 4 mo. _____ 6 mo. _____ 1 year or longer _____

WHAT IS YOUR IMMEDIATE DENTAL CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

YES NO

- 1. unhappy with the appearance of your teeth
- 2. unfavourable dental experiences
- 3. dental fears
- 4. problems with effectiveness or bad reactions to dental anesthetic
- 5. orthodontic treatment (braces), when
- 6. periodontal (gum) treatment, when
- 7. bleeding gums
- 8. avoid brushing any part of your mouth
- 9. part of your mouth is sensitive to temperature
- 10. sore teeth
- 11. a burning sensation in your mouth
- 12. difficulty swallowing
- 13. an unpleasant taste or odour in your mouth
- 14. dry mouth, throat, and/or eyes
- 15. jaw problems (temporomandibular joint)
- 16. difficulty opening your mouth widely
- 17. stiff neck muscles
- 18. awaken with an awareness of your teeth or jaw
- 19. tension headaches
- 20. clench or grind your teeth
- 21. jaw clicking or popping
- 22. lost any teeth
- 23. do you sweat or tremble a lot during examination
- 24. do strange people or places make you uncomfortable
- 25. had any trauma to your head / face / teeth (sports, car accident, whiplash, etc.)

NOTES: _____

Client's Signature _____ Date _____

Doctor's Remarks _____

_____ Doctor's Signature _____