

# Confidential Information Questionnaire

*Please Print*

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

*Please Circle Your Preferred Way of Communication Above*

<b>Children (Name(s) and Age(s))</b>			
<b>Specific Interests or Hobbies</b>			
<b>Person We Can Contact in Case of an Emergency</b>		<b>Work Phone</b>	<b>Home Phone</b>
<b>Name</b>	<b>Relationship</b>		
<b>Other Family Members That Are Clients Here</b>		<b>Who Can We Thank For Referring You?</b>	

## Insurance Information

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

*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 \_\_\_\_\_

<b>HAVE YOU EVER HAD THE FOLLOWING:</b>		<b>YES</b>	<b>NO</b>		<b>YES</b>	<b>NO</b>
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"/>
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"/> aspirin, ibuprofen, acetaminophen				26. arthritis .....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> penicillin				27. glaucoma .....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> erythromycin				28. contact lenses .....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> tetracycline				29. head or neck injuries .....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> codeine				30. epilepsy, convulsions (seizures) .....	<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"/> fluoride				32. any lumps or swelling in the mouth .....	<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"/> latex				34. venereal disease .....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> any other medications _____				35. hepatitis (type _____) .....	<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"/>
4. heart murmur .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	37. tumor, abnormal growth .....	<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"/>
6. scarlet fever .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	39. chemotherapy .....	<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"/>
8. low blood pressure .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	41. psychiatric treatment .....	<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"/>
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"/>
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"/>	<b>ARE YOU:</b>		
14. tuberculosis .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	44. presently being treated for any illness .....	<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"/>
16. sinus problems .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	46. often exhausted or fatigued .....	<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"/>
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"/>
19. jaundice .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	49. often unhappy or depressed .....	<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"/>
21. hormone deficiency .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	51. FEMALE - taking birth control pills .....	<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"/>
23. diabetes .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	53. MALE - prostate disorders .....	<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 .....	<input type="checkbox"/>	<input type="checkbox"/>
2. unfavourable dental experiences .....	<input type="checkbox"/>	<input type="checkbox"/>
3. dental fears .....	<input type="checkbox"/>	<input type="checkbox"/>
4. problems with effectiveness or bad reactions to dental anesthetic .....	<input type="checkbox"/>	<input type="checkbox"/>
5. orthodontic treatment (braces), when .....	<input type="checkbox"/>	<input type="checkbox"/>
6. periodontal (gum) treatment, when .....	<input type="checkbox"/>	<input type="checkbox"/>
7. bleeding gums .....	<input type="checkbox"/>	<input type="checkbox"/>
8. avoid brushing any part of your mouth .....	<input type="checkbox"/>	<input type="checkbox"/>
9. part of your mouth is sensitive to temperature .....	<input type="checkbox"/>	<input type="checkbox"/>
10. sore teeth .....	<input type="checkbox"/>	<input type="checkbox"/>
11. a burning sensation in your mouth .....	<input type="checkbox"/>	<input type="checkbox"/>
12. difficulty swallowing .....	<input type="checkbox"/>	<input type="checkbox"/>
13. an unpleasant taste or odour in your mouth .....	<input type="checkbox"/>	<input type="checkbox"/>
14. dry mouth, throat, and/or eyes .....	<input type="checkbox"/>	<input type="checkbox"/>
15. jaw problems (temporomandibular joint) .....	<input type="checkbox"/>	<input type="checkbox"/>
16. difficulty opening your mouth widely .....	<input type="checkbox"/>	<input type="checkbox"/>
17. stiff neck muscles .....	<input type="checkbox"/>	<input type="checkbox"/>
18. awaken with an awareness of your teeth or jaw .....	<input type="checkbox"/>	<input type="checkbox"/>
19. tension headaches .....	<input type="checkbox"/>	<input type="checkbox"/>
20. clench or grind your teeth .....	<input type="checkbox"/>	<input type="checkbox"/>
21. jaw clicking or popping .....	<input type="checkbox"/>	<input type="checkbox"/>
22. lost any teeth .....	<input type="checkbox"/>	<input type="checkbox"/>
23. do you sweat or tremble a lot during examination .....	<input type="checkbox"/>	<input type="checkbox"/>
24. do strange people or places make you uncomfortable .....	<input type="checkbox"/>	<input type="checkbox"/>
25. had any trauma to your head / face / teeth (sports, car accident, whiplash, etc.) .....	<input type="checkbox"/>	<input type="checkbox"/>

**NOTES:** \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Client's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Remarks \_\_\_\_\_

\_\_\_\_\_ Doctor's Signature \_\_\_\_\_