

MARGOLIN DENTAL ASSOCIATES, LLC
HEALTH QUESTIONNAIRE

Name _____ Soc. Sec. _____

Last Name

First Name

M.I.

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex M F Birth date _____ Single Married Widowed Separated Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Phone _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Relation to Patient _____

Home Phone _____ Cell Phone _____

Primary Insurance

Person Responsible for Account _____

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient) _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Employer Name _____ Business Phone _____

Insurance Company _____ ID # _____

Other dependants on this plan _____

Secondary Insurance

Person Responsible for Account _____

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient) _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Employer Name _____ Business Phone _____

Insurance Company _____ ID # _____

Other dependants on this plan _____

Dental History

What would you like us to do today? _____ Are you in discomfort? _____

Have you had x-rays taken in the last year? _____ Date of last dental visit _____

Check yes or no if you have had problems with any of the following:

- | | | |
|---|---|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Bad Breath | <input type="checkbox"/> Y <input type="checkbox"/> N Food collection between teeth | <input type="checkbox"/> Y <input type="checkbox"/> N Periodontal treatment |
| <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to sweets | <input type="checkbox"/> Y <input type="checkbox"/> N Bleeding gums | <input type="checkbox"/> Y <input type="checkbox"/> N Grinding or clenching teeth |
| <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to hot/cold | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity when biting | <input type="checkbox"/> Y <input type="checkbox"/> N Loose Teeth or Broken Fillings |

Medical History

Are you currently under physician care? Y N If yes, please describe _____

Physician's Name _____ Phone _____

Women: Are you pregnant? Y N Nursing? Y N Taking birth control pills? Y N

Check yes or no whether you have had any of the following:

- | | | |
|---|---|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N AIDS/HIV positive | <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N Swelling of feet ankles |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N Fainting | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis | <input type="checkbox"/> Y <input type="checkbox"/> N Food allergies | <input type="checkbox"/> Y <input type="checkbox"/> N Tobacco Habit |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial heart valves | <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial joints | <input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcer/Colitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Heart Problems | <input type="checkbox"/> Y <input type="checkbox"/> N Venereal disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Back problems | Describe _____ | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood disease | <input type="checkbox"/> Y <input type="checkbox"/> N Radiation treatment | <input type="checkbox"/> Y <input type="checkbox"/> N Herpes |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer | <input type="checkbox"/> Y <input type="checkbox"/> N Respiratory disease | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemical Dependency | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic/Scarlet fever | <input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy | <input type="checkbox"/> Y <input type="checkbox"/> N Shingles | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney Disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Circulatory problems | <input type="checkbox"/> Y <input type="checkbox"/> N Shortness of breath | <input type="checkbox"/> Y <input type="checkbox"/> N Liver disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cough, persistent | <input type="checkbox"/> Y <input type="checkbox"/> N Spina Bifida | <input type="checkbox"/> Y <input type="checkbox"/> N Nervous problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke | <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker |

Please list any and all medications _____

Please list all allergies _____

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. IF there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____