Elaine K. Sours, D.D.S., P.C.

Please fill out completely (Note: you can type directly on this form and print it out)   Today's Date ______

Patient Name ______ S. S. No. ______ Birthdate ______
Residence ______ City, State ______ Zip Code ______
Home Phone ______ Cell Phone ______ E-Mail Address ______
Height ______ Weight ______ Single ______ Married ______ Occupation ______
Employer Name______Work Phone ______ Dental Insurance ______
Policyholder Name ______ ID Number ______ Insurance Phone No.______
Spouse/Guardian Name ______ S.S. No. ______ Birthdate______
Occupation ______ Employer Name ______Work Phone ______
Referred By (We like to say "Thank You") ______Emergency Contact: ______

GENERAL HEALTH QUESTIONNAIRE **YES** **NO**

My last physical examination was on ______
Are you under the care of a physician?
a. If yes, what is the condition being treated? ______

Name and phone number of physician ______

Have you had any serious illness or operation?
a. If yes, what was the illness or operation? ______

Are you taking any medications?
a. If yes, what? ______

Are you taking the following:
a. Aspirin
b. Anticoagulants/Blood Thinner
c. Antidepressants/Tranquilizers
d. Blood Pressure Medicine
e. Cortisone (steroids)
f. Heart Medications
g. Insulin
h. Nitroglycerin

Do you have or have you had any of the following diseases or problems:
a. AIDS, ARC, HIV+
b. Arthritis
c. Artificial Heart Valves
d. Asthma
e. Cancer/Chemotherapy
f. Diabetes
g. Difficulty Breathing
h. Epilepsy/Seizures
i. Excessive Bleeding or Clotting Problems
j. GI disorders/Procedures
k. Heart Disease or Attack/Mitral Valve Prolapse
l. Hepatitis/Liver Disease
m. High Blood Pressure
n. Kidney Disease
o. Pacemaker
p. Prosthetic Hip or Joint
q. Psychiatric Treatment
r. Rheumatic Fever/Heart Murmur
s. Sinus Problems
t. Stomach Ulcers
u. Stroke
v. Thyroid
w. Tuberculosis or other Lung Disease
x. Venereal Disease

YES **NO**

Are you allergic or have you reacted adversely to:
a. Aspirin
b. Codeine or other Narcotic
c. Erythromycin
d. Latex
e. Local Anesthetics or Novacaine
f. Penicillin or other Antibiotics
g. Tetracycline

WOMEN

Do you take birth control pills?
Are you pregnant?
If yes, what is your due date? ______

DENTAL HISTORY

When did you have your last dental exam? ______
Dentist name and address ______

Have you had problems with your teeth?
If yes, what kind? ______
Are your teeth sensitive to:
a. Cold? If yes, where? ______
b. Hot? If yes, where? ______
Do your gums bleed easily?
Have you noticed any loose teeth?
Do you brush daily?
Do you floss regularly?
Have you ever had your teeth straightened?
Do you grind or clench your teeth ever?
Do you get oral herpes/fever blisters?
Do you use tobacco products? If yes, what kind?
Chew: Cigars: Cigarettes: Pipe:
Do you have TMJ/TMD or jaw joint pain?
Do you use nitrous oxide or laughing gas for dental treatment?
Do you have any fillings that feel rough or areas where food collects?
If yes, where? ______
Have you ever had or been advised to have gum/periodontal therapy?
If yes, when?
Are you happy with the way your smile looks?
If not, what would you change? ______

Patient or Guardian Signature ______ Date ______