CAIN DENTURE CENTER

Please provide complete answers to the requested information. Please print legibly.
All replies are strictly confidential. Thank you.

Today's date _____

Patient (Dr.) (Mr.) (Ms.) (Mrs.) (Miss) _____ _____ _____ Date of birth _____ Age _____
first name middle name last name

How would you like to be addressed? _____ Age of present denture _____

Address _____ City _____

State _____ Zip Code _____ E-Mail _____

Home Phone ( ) - Cell Phone ( ) -

Sex ❑ Male ❑ Female Marital Status ❑ Single ❑ Married ❑ Widowed ❑ Divorced

How did you find out about our office? _____

Patient employed by _____ ❑ Full time ❑ Part time ❑ Retired

Business Address _____ Phone ( ) -

Name of Spouse _____

Employed by _____ ❑ Full time ❑ Part time ❑ Retired

Business Address _____ Phone ( ) -

Nearest Relative _____

Address _____ Phone ( ) -

Person responsible for payment of account _____

Person assisting with filing out this questionnaire _____

Relationship to Patient _____

PLEASE ANSWER EACH QUESTION
ALL REPLIES ARE STRICTLY CONFIDENTIAL

	YES	NO
1. What prompted you to seek dental treatment or care at this time? _____		
_____		
2. Do you have difficulty in chewing your food?	❑	❑
3. Are you dissatisfied with the appearance of your teeth?	❑	❑
4. Have you ever had slow healing sores in or about your mouth?	❑	❑
5. Are you worried about receiving dental treatment?	❑	❑
6. Are you in poor health?	❑	❑
7. Have you experienced a change in your health within the last year?	❑	❑
8. Do you use tobacco? If so, how much?	❑	❑
9. Are you currently under treatment by a physician?	❑	❑
10. Are you taking any medicine of any kind (Specify)? _____	❑	❑
_____		
11 . Has a dentist or physician warned you against taking any specific medication?	❑	❑
(Specify) _____		
12. Have you ever experienced any unfavorable reaction to dental treatment?	❑	❑
(Specify) _____		
13. Do you have any habits such as nail biting, thumb sucking, etc.?	❑	❑
(Specify) _____		
14. Are there any other aspects of your health history that we should know about?	❑	❑
(Specify) _____		
15. Have you been advised to routinely take antibiotics before dental care?	❑	❑

16. Have you ever had or do you have (check all that apply):

❑ Tuberculosis	❑ Diabetes	❑ Epilepsy
❑ Asthma	❑ Heart Disease	❑ Positive HIV
❑ AIDS	❑ Sexually Transmitted Diseases	❑ Allergies
❑ Kidney or Liver Disease	❑ Surgery in the past 6 months	❑ Shortness of Breath
❑ Hepatitis	❑ High Blood Pressure	❑ Cancer
❑ Pulmonary Shunts	❑ Congenital Heart Disease	❑ Rheumatic Heart Disease
❑ History of Endocarditis	❑ Systemic Lupus	❑ Artificial Joint Infections
❑ Pain in your chest	❑ Artificial Heart Valves	❑ Immunosuppressed

Your Physician's Name _____ Address _____

Your Dentist's Name _____ Address _____

To the best of my knowledge this is an accurate statement of my health at the present time

Signature of patient _____ Date _____