

Dr Eddie C. Pruitt D.D.S
Patient Health History / Questionnaire

(Please print or Type. New patients
please bring to your appointment)

GENERAL INFORMATION

Date _____

Dr. Mr. Mrs. Miss. Ms. _____

Address _____
Last Middle First Birthdate

Home Phone _____ Work _____ Cell _____

Occupation _____ Employer _____

Employer address _____
Street City State Zip

Marital Status _____ Your Social security _____

Name of Spouse _____ Spouse Social _____

Occupation _____ Employer _____ Phone Number _____

Address of employer _____
Street City State Zip

If patient is a minor, who is legally responsible? _____ Phone _____

Address _____
Street City State Zip

How did you hear about us? Referred by: _____ Other _____

INSURANCE INFORMATION

If you have any type of dental insurance, please complete the following. If not, turn the page.

Name of Insurance carrier _____

Name of Group dental plan _____ Group number _____

Employee _____ Employee DOB _____ Emp Social Security _____

Employer _____ Phone no _____

Address _____
Street City State Zip

Is patient covered by another plan? _____ **If so**, name, address and phone number of
plan _____

Employer _____ Phone number _____

Address _____
Street City State Zip

MEDICAL HISTORY

Family Physician _____ Specialty _____

Address _____ (_____) _____
Street City State Zip Phone

Additional Physician _____ Specialty _____

Address _____ (_____) _____
Street City State Zip Phone

Height _____ Weight _____ Age _____ Date of last complete medical exam _____

Please encircle Yes or No. If YES, please fill in the details.

- YES NO Do you have a current medical problem? What? _____
- YES NO Do you have heart trouble? What kind? _____
- YES NO Have you ever been told you have a heart murmur? _____
- YES NO Have you ever had rheumatic fever? When? _____
- YES NO Do you have **HIGH** or **LOW** blood pressure? Is it controlled? _____
- YES NO Have you had chest pains or shortness of breath? _____
- YES NO Do your ankles ever swell? _____
- YES NO Has your physician ever told you that you are anemic? _____
- YES NO Have you ever had a stroke? When? _____
- YES NO Have you ever had diabetes? How is it controlled? _____
- YES NO Are you subject to fainting or dizziness? When? _____
- YES NO Do you have headaches? How often? _____
- YES NO Do you have a problem with insomnia? How often? _____
- YES NO Do you have any nervous disorders? How often? _____
- YES NO Do you take tranquilizers or sedatives? How often? _____
- YES NO Do you take aspirin? How often? _____
- YES NO **Are you ALLERGIC to any medications? What?** _____
- YES NO **Have you ever been advised to not take any medication? What?** _____
- YES NO Do you have asthma or hay fever? How is it controlled? _____
- YES NO Have you ever had tuberculosis? When? _____
- YES NO Have you ever been informed you have ARC/AIDS? _____
- YES NO Have you ever had infectious hepatitis? When? _____
- YES NO Do you have arthritis? How is it controlled? _____
- YES NO Have you ever had a tumor or cancer? How was it treated? _____
- YES NO Have you ever had any major operation? What kind? _____
- YES NO Have you ever been involved in a serious accident? _____
- YES NO **Are you taking any medication? Please list:** _____
 Taking _____ For _____ Taking _____ For _____
 Taking _____ For _____ Taking _____ For _____
 Taking _____ For _____ Taking _____ For _____
- YES NO Have you gained or lost weight in the last year? How much? _____
- YES NO Do you become fatigued easily? At what time of day? _____
- YES NO Do you routinely eat breakfast? What? _____
- YES NO Do you take more than one alcoholic drink per day? How many? _____
- YES NO Do you use tobacco? How much? _____
- YES NO Is your diet medically supervised? For what purpose? _____

FOR WOMEN

YES NO Are you pregnant? Expected delivery date? _____

Date _____

DENTAL HISTORY

Previous Dentist _____ Period of treatment _____ Specialty _____

Address _____ (_____) _____
Street City State Zip Area Code Phone

Other Dentist _____ Period of treatment _____ Specialty _____

Address _____ (_____) _____
Street City State Zip Area Code Phone

Last dental visit _____ Last full mouth X-ray _____ Last complete dental exam _____

What is your immediate dental concern? _____

Please encircle Yes or No. If YES, please fill in the details.

- YES NO Are you presently in any dental pain? _____
- YES NO **Have you experienced any unfavorable reaction to dentistry?** _____
What? _____
- YES NO Have you lost any teeth? From what cause? _____
- YES NO Have you ever had orthodontic treatment? When? _____
- YES NO Do you have any growths or swellings in your mouth? How long have the existed? _____
- YES NO Do you have difficulty in swallowing? _____
- YES NO Do your gums bleed when brushing your teeth? _____
- YES NO Do you avoid brushing any part of your mouth? Why? _____
- YES NO Have you ever been told you have pyorrhea? When? _____
- YES NO Is any part of your mouth sensitive to temperature, pressure or food or drink? _____
What? _____
- YES NO Do you have a burning sensation of your mouth? _____
- YES NO Have you ever had a bad reaction to dental anesthetic? When? _____
- YES NO Does food catch between your teeth? _____
- YES NO Do you have any pain or soreness around your eyes, ears or other parts of your face? _____
Where? _____ When? _____
- YES NO Are you aware of stiff neck muscles? How often? _____
- YES NO Do you ever awaken with pain in teeth or jaws? How often? _____
- YES NO Are you aware of clenching your teeth daytime or sleeping? How often? _____
- YES NO Do you have difficulty opening your mouth widely? _____
- YES NO Do you have tension headaches? How often? _____
- YES NO Do you have unpleasant taste or odor in your mouth? _____
- YES NO Are you dissatisfied with the appearance of your teeth? _____
- YES NO Do you feel you will eventually wear full artificial dentures? _____
- YES NO Do any members of your family including parents wear dentures? _____
- YES NO Do you think dental disease is active? _____
- YES NO Do you want to know how to control your dental disease and retain your teeth? _____
- YES NO Are you deeply concerned about finances required to return your mouth to excellent dental health? _____
- YES NO Do you get frustrated because you always have something to be treated or repaired when you visit the dentist? _____

I, understand (patient or legally responsible party), authorize dental treatment to be rendered by the Dentist and his Staff, and assume financial responsibility.

Signature _____ Date _____