PATIENT QUESTIONNAIRE

SELECTIVE DENTAL
3151 S. WHITE RD., SUITE 203
SAN JOSE, CA 95148
Office: 1-408-238-7646 Fax: 1-408-238-8096
Email: contact@selectivedentalsanjose.com

Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name_____ Soc. Sec. # _____

Last Name *First Name* *Initial*

Address _____

City _____ State_____ Zip_____ Home Phone _____

Cell Phone _____ Email _____

Sex [] M [] F Age_____ Birthdate_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by_____ Occupation_____

Business Address_____ Business Phone_____

Whom may we thank for referring you?_____

Notify in case of emergency_____ Home Phone_____

Cell Phone_____ Business Phone_____

Email_____

Primary Insurance

Person Responsible for Account_____

Last Name *First Name* *Initial*

Relation to Patient_____ Birthdate_____ Soc. Sec. #_____

Address (*if different from patient*)_____ Home Phone_____

City_____ State_____ Zip_____

Cell Phone_____ Email_____

Person Responsible Employed by_____ Business Phone_____

Insurance Company_____ Phone_____

Contract #_____ Group #_____ Subscriber #_____

Name of other dependents under this plan _____

Additional Insurance

Is patient covered by additional insurance? [] Yes [] No

Subscriber Name_____ Relation to Patient_____ Birthdate_____

Address (*if different from patient)*_____ Soc. Sec. #_____

City_____ State_____ Zip_____

Cell Phone_____ Email_____

Person Responsible Employed by_____ Business Phone_____

Insurance Company_____ Phone_____

Contract #_____ Group #_____ Subscriber #_____

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Dental History

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

Former Dentist_____ Address_____

Dentist's Email_____ Phone_____

Date of last dental care_____ Date of last x-rays_____

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

☐Y ☐N Bad breath	☐Y ☐N Food collection between teeth	☐Y ☐N Periodontal treatment	☐Y ☐N Sensitivity to sweets
☐Y ☐N Bleeding Gums	☐Y ☐N Grinding or clenching teeth	☐Y ☐N Sensitivity to cold	☐Y ☐N Sensitivity when biting
☐Y ☐N Clicking or popping jaw	☐Y ☐N Loose teeth or broken fillings	☐Y ☐N Sensitivity to hot	☐Y ☐N Sores or growths in mouth

How often do you brush?_____ Floss?_____

How do you feel about the appearance of your teeth?_____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐Y ☐N

Other information about your dental health or previous treatment_____

Medical History

Physician's name_____ Phone_____

Date of last visit_____ Have you had any serious illnesses or operations? ☐Y ☐N

If yes, describe_____

Are you currently under physician care? ☐Y ☐N If yes, describe_____

Have you had excessive bleeding when requiring treatment? ☐Y ☐N If yes, give approximate dates_____

Have you ever taken Fen-Phen/Redux? ☐Y ☐N

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

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

1. ☐Y ☐N Heart Disease	11. ☐Y ☐N Psychiatric Treatment	21. Allergies to:
2. ☐Y ☐N High blood pressure	12. ☐Y ☐N Arthritis	a. ☐Y ☐N Penicillin
3. ☐Y ☐N Blood disorder – anemia	13. ☐Y ☐N Tumor History	b. ☐Y ☐N Other Antibiotics
4. ☐Y ☐N Rheumatic Fever	14. ☐Y ☐N Venereal Disease	c. ☐Y ☐N Codeine, Aspirin
5. ☐Y ☐N Heart Murmur	15. ☐Y ☐N Sinus Trouble	d. ☐Y ☐N Local Anesthetic, Novocaine
6. ☐Y ☐N Thyroid Disease, hyperthyroidism	16. ☐Y ☐N Ulcers	e. ☐Y ☐N Latex
7. ☐Y ☐N Diabetes	17. ☐Y ☐N Radiation Treatment	22. ☐Y ☐N Asthma
8. ☐Y ☐N Stroke	18. ☐Y ☐N Liver or Kidney Disease	23. ☐Y ☐N Tuberculosis, Emphysema
9. ☐Y ☐N Epilepsy	19. ☐Y ☐N Hepatitis, Jaundice	24. ☐Y ☐N AIDS/HIV
10. ☐Y ☐N Fainting	20. ☐Y ☐N Artificial Prosthesis	25. ☐Y ☐N Cancer

Is patient currently taking any medications? If yes, list all:

_____

_____

Do you have any disease, condition, or problem not listed above?

_____

_____

ACKNOWLEDGEMENT AND AUTHORIZATION

I AUTHORIZE **SELECTIVE DENTAL** AND/OR **IT'S** STAFF TO TAKE RADIOGRAPHS, STUDY MODELS, PHOTOGRAPHS, OR ANY OTHER DIAGNOSTIC AIDS DEEMED APPROPRIATE TO MAKE A THOROUGH DIAGNOSIS.

I CERTIFY THAT I, AND/OR MY DEPENDENT (S) HAVE INSURANCE COVERAGE AND ASSIGN BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I AUTHORIZE **SELECTIVE DENTAL** TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS. **I UNDERSTAND THAT RESPONSIBILITY FOR PAYMENT FOR DENTAL SERVICES PROVIDED IN THIS OFFICE FOR MYSELF AND/OR MY DEPENDENTS IS MINE DUE AND PAYABLE AT THE TIME SERVICES ARE RENDERED.** IN THE EVENT OF DEFAULT I (WE) PROMPISE TO PAY LEGAL INTEREST ON THE INDEBTEDNESS, TOGETHER WITH SUCH COLLECTION COSTS AND REASONABLE ATTORNEY FEES AS MAY BE REQUIRED TO EFFECT COLLECTION OF THIS NOTE.

Signature_____ Date_____

Payment is due in full at time of treatment, unless prior arrangements have been approved.