ESTABLISHED 2017

ELECTRIC CITY DENTAL

DR. VERONA SULJA — FAMILY DENTISTRY — DR. KOREN BENNETTS

SULJA BENNETTS DENTISTRY PROFESSIONAL CORPORATION

CONFIDENTIAL INFORMATION QUESTIONNAIRE

Today's Date: _____

Name: _____ Birth Date: _____ Sex : ☐ M ☐ F

Address: _____ City: _____ Postal Code: _____

Home Ph: _____ Cell Ph: _____ Work Ph: _____

Email: _____ Preferred method of contact: email ☐ Ph: home ☐ Cell ☐

Occupation: _____ Employer: _____

Dental Insurance Co: _____ Group #: _____ Certificate #: _____

Person to contact in case of emergency: _____ Relationship: _____ Phone #: _____

Is any other member of your family a patient at our office? _____

How did you hear about our office? _____ Whom may we thank for referring you? _____

PATIENT MEDICAL HISTORY

Physician: _____ **Ph:** _____

		Yes	No	Not Sure/Maybe
1.	Are you being treated for any medical condition at the present or have you been treated within the past year? If so why? _____	☐	☐	☐
2.	Was your last medical check-up within the past one year? If **no,** when was it? _____	☐	☐	☐
3.	Has there been any change in your general health in the past year?	☐	☐	☐
4.	Are you taking any medications or non-prescription drugs of any kind?	☐	☐	☐
	Please list name of medication & its usage: _____			
	_____			
	_____			
5.	Do you have allergies to latex or food dyes?	☐	☐	☐
	If yes, please list allergy _____			
6.	Have you ever had allergic or adverse reaction to any medicines or injections? (e.g. penicillin, aspirin, or local anaesthetics, "dental freezing") _____	☐	☐	☐
7.	Have you ever been advised that you require antibiotic pre-medication prior to dental appointments?	☐	☐	☐
8.	Have you ever been hospitalized for any illnesses or operations?	☐	☐	☐
	Please explain: _____			

See over →

9. Do you have or have you ever had any of the following? – **Please select all that apply.**

☐ Chest Pain ☐ Lung Disease ☐ Steroid Therapy ☐ Arthritis ☐ High Blood Pressure ☐ Heart Attack ☐ Tuberculosis
☐ Diabetes ☐ Seizures ☐ HIV/AIDS ☐ Stroke ☐ Asthma ☐ Stomach Ulcers ☐ Cancer ☐ Kidney Disease
☐ Hepatitis ☐ Bleeding Disorder ☐ Artificial Heart Valve

	Yes	No	Not Sure/Maybe
10. Are there any conditions or diseases not listed above that you have or have had?	☐	☐	☐
If so, what? _____			
11. Do you or did you smoke? If so, how much? _____	☐	☐	
12. Do you use any recreational drugs or alcohol on a regular basis?	☐	☐	☐
13. How nervous are you during dental treatments? (indicate by marking this scale below)			
NOT AT ALL —1—2—3—4—5—VERY ANXIOUS			
14. If you are nervous, would you like us to consider additional techniques, along with "freezing", to help you? i.e. laughing gas	☐	☐	☐
15. Have you ever had any serious trouble with any previous dental treatments?	☐	☐	☐
16. **For women only. Are you pregnant?**	☐	☐	☐
If so, what is the expected delivery date?_____			

PATIENT DENTAL HISTORY

Name of previous dentist: _____ Date of last visit: _____

Describe any dental pain/discomfort: _____

_____

Describe what you would like done with your teeth: _____

_____

I certify that I have read and answered the above information accurately and to the best of my knowledge.

Consent For Treatment: This is to certify that I, the undersigned, verify the above information is true. I consent to the performing of dental procedures agreed to be necessary or advisable and will assume responsibility for fees associated with such procedures. I have read the office's privacy policy and I am aware of circumstances where it may be necessary to release or to obtain patient information. I give permission for photographs to be taken at my dental appointments.

_____ _____

Signature of patient, parent or guardian Date