LEVESQUE FAMILY DENTISTRY, PLLC **Patient Questionnaire**

Date ______________Home Phone _______________ Cell Phone________________ SS#________________________
Last Name___________________________First Name____________________________Middle Initial_____________
Address______________________________________City____________________Zip Code_____________________
Date of Birth_________________ Sex M/F Marital Status M/D/W

Holder of Insurance Policy_________________________________SS#____________________DOB______________
Insurance Company_______________________________________Group Number_____________________________
Address____ Phone Number_____________________________
Subscriber Employer________________________________ Insurance ID#___________________________________
Address____

Referred by__________________________________ Physician's Name_____________________________________
Emergency Contact:__________________________Phone#____
If Child, parents full name____
If college student, name of school____

DENTAL HISTORY

Chief Dental Concern____
When did you last have your teeth cleaned? ____
Yes No Are you experiencing any pain or discomfort in your mouth?
Yes No Have you ever had gum (periodontal) treatment?
Yes No Have you ever worn braces?
Yes No Are you satisfied with the appearance of your teeth?
Yes No Are you aware of clenching, or grinding your teeth together in the daytime or night?
Yes No Do you feel nervous about having dental treatment?
Yes No Have you ever had a bad experience in a dental office?
Yes No Have you been under the care of a physician the past two years?
If so, for what? ____
Yes No Are you taking any medications? Please list: (ex. Blood thinners, insulin, birth control)_____________________
____
Yes No Are you allergic to or made sick by any drugs or medications? ____
(Sulfa, Penicillin, Amoxicillin, Erythromycin, Aspirin, Latex)
Yes No WOMEN Are you pregnant? Yes No Are you nursing?
Yes No Do you smoke?

CIRCLE Yes or No of the following that you HAVE or HAVE HAD:

Yes No Heart Failure	Yes No Emphysema	Yes No Ulcer/Colitis	Yes No Heart Surgery
Yes No Heart Disease/Attack	Yes No Kidney Trouble	Yes No Drug Addiction	Yes No Thyroid
Yes No Angina Pectoris	Yes No Glaucoma	Yes No AIDS/HIV+	Yes No Stroke
Yes No Liver Disease	Yes No Tuberculosis	Yes No Hepatitis A/B/C	Yes No Allergies
Yes No Hay Fever/Sinusitis	Yes No Sinus Trouble	Yes No Asthma	Yes No High Blood Pressure
Yes No Blood Transfusion	Yes No Diabetes	Yes No Arthritis	Yes No Heart Murmur
Yes No Chemotherapy/Cancer	Yes No Hemophilia	Yes No Cold Sores	Yes No Rheumatic Fever
Yes No Pacemaker	Yes No Venereal Disease	Yes No Epilepsy/Seizures	Yes No Artificial Heart Valve
Yes No Artificial Joints	Yes No Anemia	Other:	Other:

To the best of my knowledge, all of the preceding answers are true and correct. Should I have any change in my health, or if my medicines change, I will inform the dentist at the next appointment without fail.

Signature (Patient, Parent or Guardian)____ Date__________________________________

See Reverse for Financial Policies