DR. ESTHER GUIOT AND ASSOCIATES PATIENT QUESTIONAIRE

PATIENT INFORMATION

Patient Name: _____ Date: _____

Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Birth Date: _____ Drivers License # _____

Phone (Home): _____ (Work): _____ (Cell): _____ (Email): _____

Address: _____

Street Apartment #

_____

City Province Postal Code

Employer Name: _____ Occupation: _____

Employer Address: _____

Street City Province Postal Code

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative

☐ Yellow Pages ☐ Internet Seach (pls specify website) _____ ☐ Work ☐ Other_____

Name of person or office referring you to our practice:_____

In case of emergency, we should notify:

Name: _____ Relationship: _____ Day Time Phone: _____

Name of Family Doctor: _____ Phone Number: _____

Name of Medical Specialist(s): _____ Phone Number(s): _____

HEALTH INFORMATION

Have you ever had any of the following? Please check those that apply:

Date of Last Dental Visit: _____ Reason for today's visit:_____

☐ AIDS
☐ Allergies _____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Bleeding disorders
☐ Blood Disease
☐ Cancer
☐ Cardio-vascular
☐ Chest pain,angina
☐ Codeine Allergy
☐ Cortisone treatment
☐ Diabetes
☐ Diet pill therapy
☐ Dizziness
☐ Drug/Alcohol dependency
☐ Anticoagulates
☐ Anti-epileptics
☐ Excessive Bleeding

☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Attack
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ HIV
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Lung Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Oral contraceptives
☐ Pacemaker
☐ Penicillin Allergy
☐ Prosthetic heart valve

☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Seizures (epilepsy)
☐ Shortness of breath
☐ Sinus Problems
☐ Steroid therapy
☐ Stomach Problems
☐ Stroke
☐ Thyroid disease
☐ TMJ_____
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease

Other Medication

_____

_____

HEALTH INFORMATION

Are you being treated for any medical condition at the present or have you been treated within the past year? If so why? ☐ Yes ☐ No ☐ Not sure/maybe

_____

When was your last medical checkup? : _____

Has there been any change in your general health in the past year? If yes explain ☐ Yes ☐ No ☐ Not sure/maybe

_____

Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes please list. ☐ Yes ☐ No ☐ Not sure/maybe

_____

Do you have any allergies? If you answered yes, please list using the categories below: ☐ Yes ☐ No ☐ Not sure/maybe

a) Medications
b) latex/rubber products
c) other e.g. hayfever, foods

_____

Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.
☐ Yes ☐ No ☐ Not sure/maybe

_____

Do you have or have you ever had asthma? ☐ Yes ☐ No ☐ Not sure/maybe

_____

Do you have or have you ever had any heart or blood pressure problems? ☐ Yes ☐ No ☐ Not sure/maybe

_____

Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever? ☐ Yes ☐ No ☐ Not sure/maybe

_____

Do you have a prosthetic or artificial joint? ☐ Yes ☐ No ☐ Not sure/maybe

_____

Have you ever been advised by your doctor to take antibiotics before dental treatment? ☐ Yes ☐ No ☐ Not sure/maybe

_____

Do you have any conditions or therapies that could affect your immune system e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy? ☐ Yes ☐ No ☐ Not sure/maybe

_____

Are there any conditions or diseases not listed above that you have or have had? If so, what?
☐ Yes ☐ No ☐ Not sure/maybe

_____

HEALTH INFORMATION

Are there any diseases or medical problems that run in your family? E.g. diabetes, cancer, etc)
☐ Yes ☐ No ☐ Not sure/maybe

_____

Have you ever had hepatitis, jaundice or liver disease? ☐ Yes ☐ No ☐ Not sure/maybe

_____

Do you have a bleeding problem or bleeding disorder? ☐ Yes ☐ No ☐ Not sure/maybe

_____

Have you ever been hospitalized for any illnesses or operations? If yes please explain. ☐ Yes ☐ No ☐ Not sure/maybe

_____

Do you smoke or chew tobacco products? ☐ Yes ☐ No ☐ Not sure/maybe

_____

Are you nervous during dental treatments? ☐ Yes ☐ No ☐ Not sure/maybe

_____

For women only: Are you breast feeding or pregnant? If pregnant, what is the expected delivery date?
☐ Yes ☐ No ☐ Not sure/maybe

_____

Do you require antibiotic prior to dental procedures? ☐ Yes ☐ No If yes, please explain:

_____

Have you ever had any complications during or following dental treatment e.g. reaction to local anesthetic?
☐ Yes ☐ No If yes, please explain:

_____

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain

_____

Are you now under the care of a physician? ☐ Yes ☐ No If yes, please explain:

_____

Name of Physician:_____ Phone:_____

Do you have any health problems that need further clarification? ☐ Yes ☐ No If yes, please explain:

_____

_____

DENTAL INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE

Name of Insured: _____
Last First MI

Insurance Carrier: _____ Subscriber ID #:_____ Group #: _____

Insured's Birth Date (MM/DD/YYYY): _____

Insured's Address: _____
Street City Province Postal Code

Insured's Employer Name: _____

Address: _____
Street City Province Postal Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Insurance Plan Name and Address: _____

SECONDARY DENTAL INSURANCE

Name of Insured: _____
Last First MI

Insurance Carrier: _____ Subscriber ID #:_____ Group #: _____

Insured's Birth Date (MM/DD/YYYY): _____

Insured's Address: _____
Street City Province Postal Code

Insured's Employer Name: _____

Address: _____
Street City Province Postal Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Insurance Plan Name and Address: _____

You may qualify for insurance assignment. In this case we will prepare and send your insurance paperwork on your behalf and you will only have to pay the uninsured portion of the fees at the time of treatment. **In order to setup your insurance assignment profile we require your current credit card information on file. Without this information, you will be required to pay all fees and we will assign all insurance payments to you.**

GUARDIAN INFORMATION

ONLY FILL IN THIS SECTION IF SOMEONE OTHER THAN THE PATIENT IS RESPONSIBLE FOR PAYMENT OF SERVICES

Patient Name: _____ Date: _____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Birth Date: _____ Drivers License # _____

Phone (Home): _____ (Work): _____ (Cell): _____ (Email): _____

Address: _____
Street Apartment #

_____
City Province Postal Code

Employer Name: _____ Occupation: _____

Employer Address: _____
Street City Province Postal Code

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If any of this information changes or there is any change in my health, I will inform the Dentist and Hygenist.

_____
Signature of patient, parent or guardian Date