Patient Health Questionnaire

Name: _____
First *Middle Initial* *Last*

_____Single _____Married _____Widowed _____Separated _____Divorced _____Child

Age: _____ Date of Birth: _____ Sex: Male ___ Female ___ SSN: _____

Patient Address: _____
City *State* *Zip*

Home Phone: _____ Cell Phone: _____

Email: _____ Employer Name: _____

How did you hear about our office? _____

Reason(s) for this appointment: _____ Hygiene _____Consult _____Pain/Discomfort

In case of an emergency, who should be notified? _____
Name *Phone Number*

Spouse/Significant Other: _____
First *Middle Initial* *Last* *DOB*

Dependent: _____
First *Middle Initial* *Last* *DOB*

Dependent: _____
First *Middle Initial* *Last* *DOB*

Dependent: _____
First *Middle Initial* *Last* *DOB*

Primary Insurance Medical _____ Dental _____

Subscriber: _____
First *Middle Initial* *Last*

Address (if different): _____City: _____ State: _____ Zip: _____

Home Phone: _____ Alternative Phone: _____

Email: _____ Social Security #: _____

Relationship to Patient: _____ Date of Birth: _____

Responsible Party Employer: _____ Insurance Company: _____

Contract #: _____ Group #: _____ Provider #: _____

Name of other dependents under this plan: _____

Secondary Insurance Medical _____ Dental _____

Subscriber: _____
First *Middle Initial* *Last*

Address (if different): _____City: _____ State: _____ Zip: _____

Home Phone: _____ Alternative Phone: _____

Email: _____ Social Security #: _____

Relationship to Patient: _____ Date of Birth: _____

Responsible Party Employer: _____ Insurance Company: _____

Contract #: _____ Group #: _____ Provider #: _____

Name of other dependents under this plan: _____

Medical History

Physicians Name: _____ Phone Number: _____

Date of Last Visit: _____ Have you had any serious illnesses or operations? Yes No

If yes, describe: _____

Are you currently under physician care? Yes No If yes, describe: _____

Have you taken Pre-Med in the Past? Yes No

What is your estimate of your general health? Excellent Good Fair Poor

Have you ever used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvioa, Didronela & Boniva. Yes No

Women: Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Indicate which of the following conditions you have or have had. Checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- ☐ AIDS/HIV
- ☐ Allergies to Medication
  List _____
- ☐ Material or Food Allergies
  List _____
- ☐ Latex Allergy
- ☐ Other Allergy
  List _____
- ☐ Anxiety
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Atopic (allergy prone)
- ☐ Back Problems
- ☐ Bleeding Easily/Excessive
- ☐ Cancer
  *Type*_____
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Chronic Fatigue
- ☐ Chronic Headaches
- ☐ Circulatory Problems
- ☐ Depression
- ☐ Diabetes
- ☐ Difficulty Breathing at Night
- ☐ Dizziness
- ☐ Emphysema
- ☐ Epilepsy or Seizure
- ☐ Excessive Thirst
- ☐ Fainting
- ☐ Fibromyalgia
- ☐ Frequent Ear Infections
- ☐ Frequent Awakening at Night
  # times a night _____
- ☐ Gastroesophageal Reflux (Gerd)
- ☐ Hay Fever
- ☐ Headaches
- ☐ Head Injuries
- ☐ Hearing Impairment
- ☐ Heart Murmur
- ☐ Heart Disease or Problems
  *Type*_____
- ☐ Hemophilia
- ☐ Herpes
- ☐ Hepatitis A, B or C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ History of Substance Abuse
- ☐ Insomnia
- ☐ Intestinal Disorder
- ☐ Jaw Pain
- ☐ Jaundice
- ☐ Kidney Disease or Malfunction
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Meniere's Disease
- ☐ Mental Problems
- ☐ Migraines
- ☐ Mitral Valve Prolapse
- ☐ Multiple Sclerosis
- ☐ Muscle Aches
- ☐ Muscle Fatigue
- ☐ Muscle Spasms
- ☐ Muscular Dystrophy
- ☐ Nervous System Problems/Disorder
- ☐ Neuralgia
- ☐ Organ Transplant
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Problems/Disease
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Shingles
- ☐ Shortness of Breath
- ☐ Sinus Problems
- ☐ Skin Rash/Disorder
- ☐ Sleep Apnea
- ☐ Slow Healing Sores
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Disease or Malfunction
- ☐ Tobacco Use
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcer/Colitis
- ☐ Venereal Disease
  Type _____

List all medications, drugs, pills or herbal remedies, including regular dosages of aspirin.

_____

_____

All History, *Please check all that apply:*

- ☐ Had an unfavorable dental experience
- ☐ Had trouble getting numb
- ☐ Had/Have braces, orthodontic treatment
- ☐ Had any teeth removed
- ☐ Had complications from past dental treatment
- ☐ Had any reactions to local anesthetic
- ☐ Had your bite adjusted

Dental History

- ☐ What is your estimate of your oral health? Excellent Good Fair Poor
- ☐ What would you like us to do today? _____
- ☐ Previous Dentist: _____ Phone: _____
- ☐ Date and type of last dental appointment: _____ X-Rays Yes No

Smile Characteristics, *Please check all that apply:*

- ☐ Is there anything about the appearance of your teeth that you would like to change
- ☐ Have you ever whitened (bleached) your teeth
- ☐ Have you felt uncomfortable or self-conscious about the appearance of your teeth
- ☐ Have you been disappointed with the appearance of previous dental work

Bite and Jaw Joint, *Please check all that apply:*

- ☐ You have problems with your jaw joint (i.e. popping, clicking)
- ☐ You have problems chewing
- ☐ Your teeth changed in the last 5 years (became shorter, thinner or worn)
- ☐ Your teeth are crowding or developing spaces
- ☐ You chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits
- ☐ You clench your teeth in the daytime or make them sore
- ☐ You have problems with sleep or wake up with an awareness of your teeth (pain)
- ☐ You wear or have worn a bite appliance / night guard

Tooth Structure, *Please check all that apply:*

- ☐ Cavities within past 3 years
- ☐ The amount of saliva in your mouth seems too little or you have difficulty swallowing any food
- ☐ You notice or have holes (i.e. pitting, crates) on the biting surface of your teeth
- ☐ Teeth sensitivity to hot, cold, biting, sweets or avoid brushing any part of your mouth
- ☐ Grooves or notches on your teeth, chipped teeth, or have had a toothache or cracked filling
- ☐ Food gets caught between any teeth

Gum and Bone, *Please check all that apply:*

- ☐ Gums bleed when brushing or flossing
- ☐ Treated for gum disease or were told you have lost bone around your teeth
- ☐ Notice an unpleasant taste or odor in your mouth
- ☐ History of periodontal disease in your family
- ☐ Experience gum recession or bleeding
- ☐ Had any teeth become loose on their own (without injury), or have difficulty eating an apple
- ☐ Experience a burning sensation in your 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? Yes No

Other information about your dental health or previous treatment _____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid my insurance.

Signature _____ Date _____

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

Authorization to use Photographs and/or Audio-Visual

I _____, herby authorize Mahoney Family Dentistry to use, reproduce, and/or publish photographs and/or video that may pertain to me-including my image, likeness and/or voice without compensation. I understand that this material may be used in various publications, public affairs releases, recruitment materials, broadcast public service advertising (PSA's) or for other related endeavors. This material may also appear on the Practice's or project sponsor's Internet Web Page. This authorization is continuous and may only be withdrawn by my specific rescission of this authorization. Consequently, the Practice or project sponsor may publish material, use my name, photograph, and/or make reference to me in any manner that the Practice or project sponsor deems appropriate in order to promote/publicize service opportunities.

Signature _____ Date _____

Communication

*You may opt out of email or text message communications at any time. You may do so after receiving your first email and/or text message.
*Please note: if you choose not to opt into email/text communications, you will still receive reminder postcards and phone calls.

We use this information to provide you with excellent treatment. We may disclose Patient Health Information (PHI) to third parties that perform services for Mahoney Family Dentistry in the administration of your benefits in accordance with HIPAA. These parties are required by law to sign a contract agreeing to protect the confidentiality of you PHI. Your PHI may be disclosed to an affiliate that performs services for Mahoney Family Dentistry in the administration of your benefits. Our affiliates do not sell, rent or share our users' personally identifiable information unless required by law, do not send any email or other communications without user permission, and do not send spam.

Signature _____ Date _____