JULIE A. VEERMAN, DDS, LLC

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Today's Date:_____

Name:_____Date of Birth:_____
Last First MI

If you are completing this form for another person, what is your relationship to that person?
Name: _____Relationship_____

Medical History

Medical Doctor_____ Phone number_____

1. Have you been under the care of a Physician in the last 2 years? ☐ Yes / No ☐
   If yes, Please explain_____
2. Current Medications you are taking_____
3. Have you been hospitalized or had any surgeries in the last 5 years? ☐ Yes / No ☐
   If yes, Please explain_____
4. Have you had an **adverse reaction** to any medications or local anesthetic? ☐ Yes / No ☐
   If yes, Please explain_____
5. Are you **allergic** to or have you had a bad reaction to any medications, latex or metals ☐ Yes / No ☐
   If yes, Please explain_____
6. Have you taken bone sparing drugs such as Fosamax, Actonel, Boniva or Zometa? ☐ Yes / No ☐
   If yes, How long? _____
7. Do you Smoke? ☐ Yes / No ☐ Packs per day? _____ # of years? _____
8. Do you use smokeless tobacco? Yes / No If so, how long? _____
9. Do you use alcohol? ☐ Yes / No ☐ How often? _____
10. **Women:** Are you or could you be pregnant? ☐ Yes / No ☐ Due Date? _____
    Are you post menopausal? ☐ Yes / No ☐

Emergency Contact_____ Relationship_____Phone Number_____

Please circle all that apply to you:

- ☐ A.I.D.S.
- ☐ Alcohol/Drug Addiction
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial joint
- ☐ Artificial Valve
- ☐ Asthma
- ☐ Blood Thinners
- ☐ Blood Transfusion
- ☐ Cancer/Tumors
- ☐ Chest Pains
- ☐ Cong. Heart Disease
- ☐ Diabetes
- ☐ Epilepsy or Seizures
- ☐ Fainting or Dizzy spells
- ☐ Glaucoma
- ☐ Low Blood Pressure
- ☐ H.I.V. Positive
- ☐ Hearing Problem
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hepatitis A, B, or C
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Neurological Disorders
- ☐ Pins or screws
- ☐ Psychiatric Care
- ☐ Radiation/Chemo
- ☐ Rheumatic Fever
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Stomach Trouble
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Tuberculosis

Name_____,_____
Last First

Dental History

Previous Dentist Name_____ Phone Number_____
Address_____

Purpose of Initial Visit to our office_____
Are you aware of any problems?_____

Date of last dental visit?_____
When was your last cleaning? _____
Were x-rays taken? ☐ Yes / No ☐
Do your gums bleed or hur ☐ Yes / No ☐
How often do you brush?_____
How often do you floss?_____
History of gum surgery ☐ Yes / No ☐
If yes, when?_____
Removed or lost any teeth ☐ Yes / No ☐
If yes, why?_____

Do you clench or grind your teeth?	☐ Yes	No ☐
Any soreness or pain in your jaw?	☐ Yes	No ☐
Does food get caught in your teeth?	☐ Yes	No ☐
Do you have sensitive teeth?	☐ Yes	No ☐
Does your jaw lock or pop?	☐ Yes	No ☐
Do you have frequent headaches?	☐ Yes	No ☐
Are you happy with the appearance of your smile?	☐ Yes	No ☐
Have you had orthodontic work?	☐ Yes	No ☐

Any complications or problems with previous dental treatment ☐ Yes / No ☐
If yes, please explain:

Do you have any questions or concerns to talk to the doctor about? ☐ Yes / No ☐
If yes, please explain:

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Parent/Legal Guardian Date

OFFICE USE ONLY:
_____
_____
_____