



Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
First MI Last

Male  Female Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_-\_\_\_\_-\_\_\_\_  
Month Day Year

Title: \_\_\_\_\_ Martial Status:  single  married  separated  divorced  widowed

Home Address: \_\_\_\_\_  
Street City State Zip

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone \_\_\_\_\_

Fax #: \_\_\_\_\_ E-mail \_\_\_\_\_

Company/Employer Name: \_\_\_\_\_ Position: \_\_\_\_\_

Name of Spouse: \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
First MI Last

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_-\_\_\_\_-\_\_\_\_  
Month Day Year

Person responsible to pay for this account: \_\_\_\_\_

**FOR INSURANCE VERIFICATION PURPOSES ONLY**

Name of Subscriber: \_\_\_\_\_ Insurance ID#: \_\_\_\_\_ Group/Policy# \_\_\_\_\_

Name of Company (employer) insurance is through: \_\_\_\_\_

Name of Dental Insurance: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Mailing Address: \_\_\_\_\_

**WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?** \_\_\_\_\_  
Friend / Relative / Associate

**Or how did you hear about Loza Dental Great Falls?**

Advertising  Web Site  Other \_\_\_\_\_

JOSE LOZA, DDS | JUAN LOZA, DDS

# HEALTH QUESTIONNAIRE

## MEDICAL HISTORY

- Circle Yes or No
- Name and phone number of physician: \_\_\_\_\_ Yes No
  - When was your last physical examination? \_\_\_\_\_ Yes No
  - Do you have any health problems? \_\_\_\_\_ Yes No
  - Have you been hospitalized or had a serious illness or operation within the past five years? \_\_\_\_\_ Yes No  
If yes, for what reason? \_\_\_\_\_
- Do you have or have you had any of the following diseases or problems?
- Rheumatic fever or rheumatic heart disease \_\_\_\_\_ Yes No
  - Congenital heart lesions, a heart murmur or mitro valve prolapse \_\_\_\_\_ Yes No
  - Cardiovascular disease (heart attack, high/low blood pressure,stroke, angina or arteriosclerosis) \_\_\_\_\_ Yes No
  - Hepatitis A, B or C, jaundice or liver disease \_\_\_\_\_ Yes No
  - Allergies \_\_\_\_\_ Yes No
  - Asthma or hay fever \_\_\_\_\_ Yes No
  - Fainting spells or seizures \_\_\_\_\_ Yes No
  - Diabetes \_\_\_\_\_ Yes No
  - Arthritis \_\_\_\_\_ Yes No
  - Tuberculosis \_\_\_\_\_ Yes No
  - Do you have a persistent cough or cough up blood \_\_\_\_\_ Yes No
  - Venereal disease \_\_\_\_\_ Yes No
  - Hip or joint surgery/replacement \_\_\_\_\_ Yes No
  - Other \_\_\_\_\_ Yes No
- Do you need to be pre-medicated before dental treatment? \_\_\_\_\_ Yes No  
Which antibiotic? \_\_\_\_\_
  - Have you had abnormal bleeding associated with previous extractions, surgery or trauma? \_\_\_\_\_ Yes No
  - Do you have any blood disorders, such as anemia? \_\_\_\_\_ Yes No
  - Have you had surgery or radiation treatment for a tumor, growth or other condition of your head or neck? \_\_\_\_\_ Yes No
  - Are you taking any of the following drugs or medications?
    - Antibiotics or sulfa drugs \_\_\_\_\_ Yes No
    - Medicine for high blood pressure \_\_\_\_\_ Yes No
    - Anticoagulants (blood thinners) \_\_\_\_\_ Yes No
    - Cortisone (steriods) \_\_\_\_\_ Yes No
    - Tranquilizers \_\_\_\_\_ Yes No
    - Aspirin \_\_\_\_\_ Yes No
    - Insulin, tolbutamide (orinase) or similar drug \_\_\_\_\_ Yes No
    - Digitalis or drugs for heart trouble \_\_\_\_\_ Yes No
    - Nitroglycerin \_\_\_\_\_ Yes No
    - Hormone therapy \_\_\_\_\_ Yes No
    - Other \_\_\_\_\_ Yes No

- Do you use tobacco products? \_\_\_\_\_ Yes No  
If so, what kind and how often? \_\_\_\_\_
- Are you HIV positive? \_\_\_\_\_ Yes No
- Are you allergic or have you reacted adversely to:
  - Local anesthetics \_\_\_\_\_ Yes No
  - Penicillin or other antibiotics \_\_\_\_\_ Yes No
  - Sulfa drugs \_\_\_\_\_ Yes No
  - Barbiturates, sedatives or sleeping pills \_\_\_\_\_ Yes No
  - Aspirin \_\_\_\_\_ Yes No
  - Iodine \_\_\_\_\_ Yes No
  - Latex \_\_\_\_\_ Yes No
  - Other \_\_\_\_\_ Yes No
- Do you have any disease, condition or problem not listed above that you think I should know about? \_\_\_\_\_ Yes No  
If so, please explain \_\_\_\_\_

## WOMEN ONLY

- Are you pregnant? \_\_\_\_\_ Yes No
- Are you taking oral contraceptives? \_\_\_\_\_ Yes No

## DENTAL HISTORY

- How long since you have been to the dentist? \_\_\_\_\_
- What was done then? \_\_\_\_\_
- Did you have x-rays? \_\_\_\_\_
- Have you lost any teeth? \_\_\_\_\_ why? \_\_\_\_\_
- Are your teeth sensitive to heat? \_\_\_\_\_ cold? \_\_\_\_\_ sweets? \_\_\_\_\_ sour? \_\_\_\_\_
- How often do you brush your teeth? \_\_\_\_\_ when? \_\_\_\_\_
- Do you use dental floss? \_\_\_\_\_ how often? \_\_\_\_\_
- Do you have bleedings gums? \_\_\_\_\_ when? \_\_\_\_\_
- Do you grind or clench your teeth? \_\_\_\_\_ when? \_\_\_\_\_
- Have you ever had gum treatments? \_\_\_\_\_ when? \_\_\_\_\_
- Do you hear popping, clicking, or snapping noises when you chew? \_\_\_\_\_
- Are you aware of any swelling or lump in your mouth? \_\_\_\_\_
- Have you had any serious trouble associated with any previous dental treatment? \_\_\_\_\_  
If so, explain \_\_\_\_\_

**Please describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your dental treatment.**

Date \_\_\_\_\_ Signature of Patient \_\_\_\_\_

Signature of Dentist \_\_\_\_\_

*Thank you for supplying us with the necessary information.*

JOSE LOZA, DDS | JUAN LOZA, DDS

