



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

- | | | |
|---|-----|----|
| 1. Name and phone number of physician: _____ | Yes | No |
| 2. When was your last physical examination? _____ | Yes | No |
| 3. Do you have any health problems? _____ | Yes | No |
| 4. Have you been hospitalized or had a serious illness or operation within the past five years?
If yes, for what reason? _____ | Yes | No |
| Do you have or have you had any of the following diseases or problems? | | |
| <input type="checkbox"/> Rheumatic fever or rheumatic heart disease _____ | Yes | No |
| <input type="checkbox"/> Congenital heart lesions, a heart murmur or mitro valve prolapse _____ | Yes | No |
| <input type="checkbox"/> Cardiovascular disease (heart attack, high/low blood pressure,stroke, angina or arteriosclerosis) | Yes | No |
| <input type="checkbox"/> Hepatitis A, B or C, jaundice or liver disease _____ | Yes | No |
| <input type="checkbox"/> Allergies _____ | Yes | No |
| <input type="checkbox"/> Asthma or hay fever _____ | Yes | No |
| <input type="checkbox"/> Fainting spells or seizures _____ | Yes | No |
| <input type="checkbox"/> Diabetes _____ | Yes | No |
| <input type="checkbox"/> Arthritis _____ | Yes | No |
| <input type="checkbox"/> Tuberculosis _____ | Yes | No |
| <input type="checkbox"/> Do you have a persistent cough or cough up blood _____ | Yes | No |
| <input type="checkbox"/> Venereal disease _____ | Yes | No |
| <input type="checkbox"/> Hip or joint surgery/replacement _____ | Yes | No |
| <input type="checkbox"/> Other _____ | Yes | No |
| 6. Do you need to be pre-medicated before dental treatment? _____
Which antibiotic? _____ | Yes | No |
| 7. Have you had abnormal bleeding associated with previous extractions, surgery or trauma? | Yes | No |
| 8. Do you have any blood disorders, such as anemia? _____ | Yes | No |
| 9. Have you had surgery or radiation treatment for a tumor, growth or other condition of
your head or neck? _____ | Yes | No |
| 10. Are you taking any of the following drugs or medications? | | |
| <input type="checkbox"/> Antibiotics or sulfa drugs _____ | Yes | No |
| <input type="checkbox"/> Medicine for high blood pressure _____ | Yes | No |
| <input type="checkbox"/> Anticoagulants (blood thinners) _____ | Yes | No |
| <input type="checkbox"/> Cortisone (steriods) _____ | Yes | No |
| <input type="checkbox"/> Tranquilizers _____ | Yes | No |
| <input type="checkbox"/> Aspirin _____ | Yes | No |
| <input type="checkbox"/> Insulin, tolbutamide (orinase) or similar drug _____ | Yes | No |
| <input type="checkbox"/> Digitalis or drugs for heart trouble _____ | Yes | No |
| <input type="checkbox"/> Nitroglycerin _____ | Yes | No |
| <input type="checkbox"/> Hormone therapy _____ | Yes | No |
| <input type="checkbox"/> Other _____ | Yes | No |

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11. Do you use tobacco products? _____ Yes No
If so, what kind and how often? _____
12. Are you HIV positive? _____ Yes No
13. 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
14. 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

15. Are you pregnant? _____ Yes No
16. 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.

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DENTAL

HEALTH & WELLNESS

HEALTH & WELLNESS
Great Falls
Healthy Smiles



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