OUSBORNE AND KELLER, D.D.S., P.A.

Adult Examination Questionnaire

Date__________________

Name (Last, First, Middle) ____________________________________ I prefer to be called ___________

Address __________________________________ City ________________ State _____ Zip __________

Home Phone ___________________ Work Phone _________________ Cell Phone _________________

E-Mail _________________________________ Preferred Method of Contact ______________________

Date of Birth ___/___/___ Sex ____ Height __________ Weight __________ Marital Status___________

Occupation __________________ SS# ______________Drivers License # ________________________

Emergency Contact __________________________ Relationship ______________ Phone ____________

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

Whom may we thank for the referral? ____

Dental Insurance

Insurance Company Name _______________________ Insurance Company Telephone # ____________

Insurance Company Address ____

Plan/Group # ____________________ ____Subscriber ID # ___________________________________

Policy Holders Name __________________________________ Policy Holders Date of Birth ___/___/___

Policy Holders Employer ___________________________Relationship to Patient ___________________

We are considered an 'out of network provider' for all insurance companies. We do not directly accept insurance assignment of benefits. We, however, recognize how important it is for you to receive your dental benefits as soon as possible. Although we are not a party to the contractual arrangement with your insurance company, we do want to help you to receive the maximum reimbursement to which you are entitled.

As a convenience to you we will complete the insurance form for you at every visit and file it electronically (when possible) with your insurance company. We will also gladly provide any documentation required to process your claim. We will do everything within our power to make sure that you always receive the maximum benefit possible.

Please remember that you are ultimately responsible for all fees incurred by our office regardless of your specific insurance coverage.

Medical Information

For the following questions, please circle YES or NO, whichever applies. Your answers to these questions are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your visit you may be asked 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.

Are you in good health? ....YES NO

Have there been any changes in your general health within the past year? ....YES NO

If yes, please explain: ____

Primary care physician name: ______________________________________ Telephone: ____________

Are you currently being treated by a specialist? …………………………………………………………..……YES NO

If yes, what is/are the condition(s) being treated? ____

Are you currently taking any medicine(s) including non-prescription medicine? …………………..Yes NO

*Please list **all** prescription, non-prescription, vitamins, and herbal and diet supplements*:

NAME OF MEDICATION (ex: atenolol)	CONDITION BEING TREATED (ex: blood pressure)
____	____
____	____
____	____
____	____
____	____
____	____

Are you taking, or scheduled to begin taking, either of the medications alendronate (Fosamax) or risedronate (Actonel) or other oral bisphosphonates? …………………………………………………… YES NO

Since 2001, were you treated, or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa)? ………………………………………………………………………… YES NO

Are you alcohol and/or drug dependent? …………………………………………………………………………. YES NO

Do you use tobacco (smoking, snuff, chew or E-Cigarettes)? .... YES NO

Do you wear contact lenses? ……………………………………………………………………………………………. YES NO

Are you ALLERGIC to or have you had a reaction to:

Local anesthetics .... YES NO DON'T KNOW

Aspirin/Acetominophen/Ibuprofen (Nsaids) .... YES NO DON'T KNOW

Penicillin or other antibiotics: Please indicate: __________________________ YES NO DON'T KNOW

Barbiturates, sedatives, or sleeping pills ....YES NO DON'T KNOW

Sulfa drugs ....YES NO DON'T KNOW

Codeine or other narcotics .... YES NO DON'T KNOW

Latex .... YES NO DON'T NOW

Iodine .... YES NO DON'T KNOW

Hay Fever/seasonal allergies .... YES NO DON'T KNOW

Metals (Please specify) ____YES NO DON'T KNOW

Other Allergies(Please specify) ____YES NO DON'T KNOW

Have you had a joint replacement **AND** been told to take an antibiotic before dental visits?......YES NO

Do you have any other conditions that require you to premedicate prior to dental visits?.........YES NO

If so, please list the condition(s) and the name of the antibiotic(s)__________________________________

____

Please list any previous surgeries, dates and/or complications: ___________________________________

____

Women Only

Are you or could you be pregnant? ....YES NO DON'T KNOW
Taking birth control pills or hormonal replacement? ....YES NO
Are you currently nursing? .... YES NO

Please CIRCLE a response to indicate if you currently have or have had any of the following DISEASES or CONDITIONS:

Abnormal bleeding .... YES NO

AIDS or HIV infection .... YES NO

Anemia .... YES NO

Arthritis..YES NO

Rheumatoid Arthritis .... YES NO

Asthma .... YES NO

Cancer.. YES NO

Chemotherapy/Radiation ....YES NO

Hemophilia .... YES NO

Hepatitis, jaundice, liver disease ....YES NO

Recurrent infections .... YES NO

If yes, indicate type ________________________

Kidney problems...................................... YES NO

Mental health disorders .... YES NO

Neurological disorder ....YES NO

Transplanted Organs ....YES NO

Cardiovascular disease ………………….. YES NO

__Angina

__Arteriosclerosis

__Artificial heart valves

__Congenital defects

__Congestive heart failure

__Cardiomyopathy

__ Coronary artery disease

__Damaged valves

__Heart attack

__Heart Murmur

__High Blood Pressure

__Low Blood Pressure

__ Mitral valve prolapse

__ Pacemaker /Defibrillator

__ Rheumatic heart disease

__Endocarditis

Usual Blood Pressure _________/___________

Disease, drug, or radiation induced Immunosurpression ……………………….. YES NO

Diabetes ……………………………………….. YES NO

__Type I __Type II

Blood Sugar Level Ac1 ________________

Dry Mouth …………………………………….. YES NO

Eating disorder ……………………………… YES NO

Epilepsy ……………………………………….. YES NO

Fainting spells or seizures ………………. YES NO

Osteoporosis …………………………….. YES NO

Persistent swollen gland in neck …..YES NO

Trouble Swallowing ……………………..YES NO

Respiratory problems ………………….. YES NO

if yes, explain: ______________________

Severe headaches/migraines ………. YES NO

Sexually transmitted diseases ……… YES NO

Sinus trouble ………………………………..YES NO

Sleep apnea/snoring…………………… YES NO

Sores or ulcers in the mouth ………. YES NO

Stroke ………………………………………… YES NO

Systemic lupus erythematosus …… YES NO

Tuberculosis …………………………….. YES NO

Thyroid problems ………………………. YES NO

Stomach Ulcers …………………………. YES NO

Gastrointestinal disease …………….. YES NO

Glaucoma ………………………………….. YES NO

G.I. Reflux/persistent heartburn…. YES NO

Do you have any disease or condition not listed above that you think I should know about? …….. YES NO

If yes, please explain: ____

Thank you for your cooperation in completing this form. If there is any other information which you feel would be of value to us in your dental treatment, please list it below:

____

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NOTES:

-Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

-Missed appointments: A charge may be accessed for failed or cancelled appointments with less than <u>48 hours prior notification</u>. Once an appointment has been agreed upon we commit our talents and resources to care for you. Please remember that this time was reserved exclusively for you and your dental needs.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquires 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: ____

(Patient/Parent/Legal Guardian)

Date: ______________________

Please list others with whom we may share information regarding your dental treatment and/or fees:

____

____

Signature of Dentist: ____

Date: _______________________

ADDITIONAL NOTES:

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