George Ghaly, DDS, PC
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508-366-1911

Dental Health Questionnaire

Correct answers to the following questions will allow our office to treat you on a more individual basis, providing the care appropriate for your particular needs. Your answers are completely confidential.

Patient Information

First Name: _____ Middle Name: _____ Last Name: _____

Nickname: _____ Email: _____

Today's Date: ____/____/____
Address: _____
City, State, Zip: _____
Social Sec. #: _____
Sex: □ Male □ Female
Date of Birth: ____/____/____ Age:

Occupation: _____
Employer: _____

Home Phone: ( )
Work Phone: ( )
Mobile Phone: ( )
Emergency contact: _____
Emergency contact phone: ( )
For minors only, parent's names?
_____

Employer Address _____
City, State, Zip _____

Insurance Information

Insurance company: _____
Subscriber: _____
Subscriber's Social Sec. #: _____

Subscriber's Employer: _____
Relationship to patient: _____ dob: ____
Group Number: _____

I certify that I, and/or my dependents, have insurance coverage. I assign directly to Dr. Ghaly all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I authorize the use of my signature on all insurance submissions.

Signature of Patient, Parent or Guardian _____

Please print name _____

Medical Information

Physicians name: _____
Date of last doctor's visit: ____/____/____
Do you have any serious medical condition that requires monitoring or medication? □ Yes □ No
If yes, what is that condition?

Do you currently, or have you ever had any problems in the following areas:

Asthma	□ Yes	□ No	Hepatitis	□ Yes	□ No
Diabetes	□ Yes	□ No	Blood disease or Anemia	□ Yes	□ No
High blood pressure	□ Yes	□ No	Sexually transmitted diseases	□ Yes	□ No
Headaches/Migraine	□ Yes	□ No	Ears, Nose, Throat	□ Yes	□ No
Cancer	□ Yes	□ No	Heart murmur	□ Yes	□ No
Mitral valve prolapse	□ Yes	□ No	Fainting or dizziness	□ Yes	□ No
HIV	□ Yes	□ No			

If you answered **YES** to any of the above or are currently under the care of a physician for any condition not listed above, please explain:

Are you pregnant? □ Yes □ No
Are you planning for pregnancy within 3 months? □ Yes □ No

Do you have any artificial valves or prosthesis, anywhere in your body, such as knee, heart, or hip replacements? □ Yes □ No

Please list all medications you are taking.

Medication	Dosage	Medication	Dosage

Please list all medication and food allergies.

Dental Information	
Are you having any discomfort at this time? □ Yes □ No	If yes, where? □ Upper □ Lower □ Right □ Left □ Can't tell
Does dental treatment make you nervous? □ Yes □ No	
Former dentist name: _____	City and State: _____
Date of last dental visit: ____/____/____	
Tell me about your past dental experiences:	
What would you like to change about your smile?	_____
Do you have bleeding gums, blisters, ulcers, swellings or growths in your mouth? □ Yes □ No	If yes, where? □ Upper □ Lower □ Right □ Left □ Can't tell
Do you feel you have bad breath? □ Yes □ No	
Do you have sensitivity to cold, heat, biting or sweets? □ Yes □ No	If yes, where? □ Upper □ Lower □ Right □ Left □ Can't tell
Have you ever been treated for periodontal disease? (gum disease) □ Yes □ No	

What are the things that are most important about your dental health?	□ Teeth should not hurt □ Cosmetics and esthetics □ No pain with normal mouth function □ Maintenance procedures only □ Keeping costs down

Please select the answers that apply to you

A. I think the appearance of my mouth is	□ excellent □ adequate □ acceptable □ hideous
B. I will do anything to	□ keep my natural teeth. □ to keep my teeth but I have a certain budget of time and money
C. I have	□ always done the best that was recommended for my oral health. □ not done what dentists have recommended. □ not cared much about having any dental work completed.
D. I think my present state of dental health is	□ excellent. □ good. □ poor.

What are some questions about dentistry and oral health that you have never had adequately answered?
Our goal is to provide you with the finest and most state of the art dentistry. In so doing, we hope to keep you as a patient for a lifetime. What would help us accomplish this goal?
What do you expect from our office?

Patient Name _____ Signature _____ Date _____

Doctor Name _____ Signature _____ Date _____

09/05