HOTsmile LLC
General & Implant Dentistry

Dr. Susan K. Wilson/ Dr. Maurina L. Brooks
60 S. James Road, Columbus, OH 43213

Patient Questionnaire

BASIC INFORMATION

First Name:_____**Middle Initial:**_____ **Last Name:**_____

Address:_____

City:_____ **State:**_____ **Zip Code:**_____

Home Phone:_____ **Cell Phone:**_____

Email:_____

Appointment Confirmation Preference: Telephone Email Both **(please circle)**

Birthdate:_____**(MM/DD/YYYY) Age:**_____ **SSN#:**_____

Sex: M/ F **(please circle)** **Marital Status:** Single, Married, Separated, Divorced, Widowed **(please circle)**

Physician Name:_____ **Phys Phone:**_____

Preferred Pharmacy:_____ **Pharm Phone:**_____

*****Do you require pre-medication prior to your dental treatment (i.e. antibiotic)?** Yes No

Emergency Contact:_____ **Relationship**_____**Phone:**_____

Employment Status: Full Time, Part Time, Self-Employed, Retired, Other_____ **(please circle)**

RESPONSIBLE PARTY

First Name:_____**Middle Initial:**_____ **Last Name:**_____

Address:_____

City:_____ **State:**_____ **Zip Code:**_____

Home Phone:_____ **Cell Phone:**_____

Email:_____

Birthdate:_____ **SSN#:**_____ **Relationship to patient:**_____

□**Primary Insurance Holder** □**Secondary Insurance Holder**

INSURANCE INFO

Insurance Co. Name:_____ **Phone:**_____

Subscriber Name:_____ **Subscriber Birthdate:**_____

Subscriber ID or SSN# _____ **Patient Relationship:** Self, Spouse, Dependent

Address (if different from patient)_____

City, State, Zip_____

Subscriber Employer:_____ **City, State:**_____

More than one Insurance? Yes or No If yes, **Secondary Ins. Co. Name**_____

Subscriber Name, Birthdate, SSN/ ID, Employer:_____

_____

*Please provide the receptionist with your **insurance card** (if applicable) and a current **photo ID**.

MEDICAL HISTORY

Are you currently under the care of a physician?	Yes	No
Have you ever been hospitalized or had a major operation?	Yes	No
Have you ever had a serious head or neck injury?	Yes	No
Are you taking any medications, vitamins or nutritional supplements? PLEASE LIST BELOW	Yes	No
Have you ever taken Fosamax, Boniva, Actonel or an other medications containing biophosphates?	Yes	No
Are you on a special diet?	Yes	No
Do you use tobacco?	Yes	No
Do you use controlled substances (including Marijuana (Cannabis))?	Yes	No
Have you ever worn braces (traditional or Invisalign ®)?	Yes	No
Do you often notice an unpleasant taste in your mouth?	Yes	No

If you answered **"yes"** to any of the above questions, please explain as completely as possible below. (Attach additional pages, if needed. Include your name and date of birth on these pages):

_____

Are you allergic to any of the following? (Please circle all that apply)

Aspirin; Penicillin; Codeine; Sulfa Drugs; Acrylic; Metal; Latex; Local Anesthetics; Other_____

WOMEN: ARE YOU…

pregnant/ trying to get pregnant? Yes No **Taking oral contraceptives?** Yes No **Nursing?** Yes No

Do you have, or have you had ANY of the following? (please circle all that apply to you)

AIDS/ HIV Positive	Convulsions	Heart Disease	Renal Dialysis
Alzheimer's Disease	Cortisone Medicine	Hemophilia	Rheumatic Fever
Anaphylaxis	Diabetes	Hepatitis A	Scarlet Fever
Anemia	Dizziness	Hepatitis B or C	Shingles
Angina	Drug Addiction	Herpes	Sickle Cell Disease
Arthritis/ Gout	Easily Winded	High Blood Pressure	Sinus Trouble
Artificial Heart Valve	Emphysema	Hives or Rash	Spina Bifida
Artificial Joint	Epilepsy or Seizures	Hypoglycemia	Stomach/ Intestinal Disease
Asthma	Excessive Bleeding	Irregular Heartbeat	Stroke
Blood Disease	Excessive Thirst	Kidney Problems	Swelling of Limbs
Blood Transfusion	Fainting Spells	Leukemia	Thyroid Disease
Breathing Problem	Frequent Cough	Liver Disease	Tonsillitis
Bruise Easily	Frequent Diarrhea	Low Blood Pressure	Tuberculosis
Cancer	Frequent Headaches	Lung Disease	Tumors or Growths
Chemotherapy	Genital Herpes	Mitral Valve Prolapse	Ulcers
Chest Pains	Glaucoma	Joint Pain	Venereal Disease
Cold Sores/ Fever Blisters	Hay Fever	Parathyroid Disease	Yellow Jaundice
Congenital Heart Disorder	Heart Attack/ Failure	Psychiatric Care	
	Heart Murmur	Radiation Treatments	
	Heart Pace Maker	Recent Weight Loss	

Have you ever had a serious illness that is not listed above? Yes No If yes, please explain _____

To the best of my knowledge, all of the questions on this form have been answered accurately and completely. I understand that providing false information can be dangerous to my (or patient's) health. I understand that it is my responsibility to notify this dental office of any changes to my medical status.

Printed Name of Patient/ Guardian _____

***Signature of Patient,** Parent or Guardian_____Date_____