Dr M.Y.M. Youssef
Dental Surgeon
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Please note: The personal data on the questionnaire will remain confidential. Providing us with adequate answers is essential for your protection as it will help us offer you the best care and service. By filling out both sides of this sheet carefully and clearly, you will help us capture the most accurate information on your patient chart. Thank you.

DATE _____

LAST NAME _____ *FIRST NAME* _____

HOME PHONE _____ *BUSINESS PHONE* _____ *EXT.*_____ *CELL PHONE* _____

ADDRESS _____ *APT* _____ *POSTAL CODE* _____

EMAIL _____

MARRIED ☐ *SINGLE* ☐ *DATE OF BIRTH* _____ *AGE* _____

OCCUPATION _____ *EMPLOYER*_____

ADDRESS _____

If patient is a minor, who is responsible? _____

PURPOSE OF TODAY'S VISIT _____

NAME, ADDRESS AND PHONE NUMBER OF FAMILY DOCTOR _____

Whom may we thank for referring you to this office? _____

Please circle the correct answers where possible:

	Yes	No	
Serious illnesses?	☐	☐	Explain_____
Rheumatic fever?	☐	☐	Explain_____
Serious operations?	☐	☐	Explain_____
Heart or blood pressure problems?	☐	☐	Explain_____
Lung or breathing problems?	☐	☐	Explain_____
Liver or kidney problems?	☐	☐	Explain_____
Anemia?	☐	☐	Explain_____
Bleeding tendencies?	☐	☐	Explain_____
Hay fever, asthma, other allergies?	☐	☐	Explain_____
Diabetes?	☐	☐	Explain_____
Epilepsy?	☐	☐	Explain_____
Digestion problems?	☐	☐	Explain_____
Venereal diseases?	☐	☐	Explain_____
Thyroid problems?	☐	☐	Explain_____
Have you ever undergone radiotherapy treatments (for a tumor)?	☐	☐	Explain_____
Are you allergic to? (please check boxes that apply)	☐	☐	Penicillin ☐ Codeine ☐ Other drugs ☐
Are you now (or been within the last year) under treatment by a physician?	☐	☐	Explain_____
Are you now taking any medicines regularly?	☐	☐	Explain_____
For Women: Are you pregnant now?	☐	☐	In my _____month
Are you apprehensive about dental treatment?	☐	☐	
If so, would you like some sedation technique to help you overcome that?	☐	☐	
Do you smoke?	☐	☐	Explain_____
Would you be available for an appointment on short notice ?	☐	☐	
Do you have some form of dental insurance ?	☐	☐	If yes, with what Company _____

Primary policy holder if not yourself: _____ _____

Name of person responsible for your account _____

Your spouse Name _____**Occupation**_____

Employer _____ **Address**_____ **Business phone & Ext.**_____

Please complete reverse side ➔

DENTAL HISTORY

Previous dentist _____

When was your last dental appointment? _____

For what purpose? _____

Have ever had orthodontic treatment? _____ If yes, who was your doctor? _____

	Yes	No	
Have you had a complete dental examination (including X-rays) within the past three years?	☐	☐	Explain_____
Have you had your teeth cleaned regularly?	☐	☐	Explain_____
Have missing teeth been replaced?	☐	☐	Explain_____
If not replaced, are you concerned about the possible outcome?	☐	☐	Explain_____
Have you been instructed about the proper home care?	☐	☐	Explain_____
Do you use dental floss or tape?	☐	☐	How often? _____
How often do you brush your teeth?	☐	☐	_____
Are your teeth sensitive to (please check boxes that apply):	☐	☐	Heat ☐ Cold ☐ Sweet ☐ Biting ☐
Do you favor one side for chewing?	☐	☐	If yes, which side?_____
Do you clench or grind your teeth?	☐	☐	
Do any teeth feel loose?	☐	☐	
Do you have any food traps?	☐	☐	
Have you noticed any gum swelling around any teeth?	☐	☐	
Do your gums bleed when brushing?	☐	☐	
Have you had any previous injuries to your face or jaw?	☐	☐	Explain_____
Have your gums ever been treated?	☐	☐	Explain_____
Do you seem to strike some teeth before others when closing?	☐	☐	
Have you ever had your bite adjusted?	☐	☐	
Have you ever experienced problems with freezing?	☐	☐	Explain_____

Thank you!

Signature: _____

Reviewed by the doctor _____