DAVID WICKNESS, DMD

BELLE MEADE • NASHVILLE

HEALTH QUESTIONNAIRE

Name _____ Date of birth _____

Address _____ City/State _____

Zip _____ Home phone _____ Cell phone _____ SS# _____

Occupation _____ Employed by _____

Work address _____ City/State/Zip _____

Work phone _____ Email address _____

Spouse _____ Employer _____ Work phone _____

Spouse SS# _____ Student/School _____

Nearest relative not living at home _____ Relation _____

Home phone _____ Work phone _____

Physician name _____ Address _____

City/State/Zip _____ Phone _____

Pharmacy name _____ City/State _____ Phone _____

Dental treatment: Last cleaning _____ Last x-rays _____ Type of toothbrush _____
hard, soft, etc.

Frequency of dental visits _____ Frequency of flossing _____

Other dental aids (Waterpik, electric toothbrush, etc.) _____

If transferring, previous dentist's name _____ Phone _____

Address _____ City/State/Zip _____

Have you been happy with your past dental care? Yes ____ No ____

Why or why not? _____

How may we make your dental visit more comfortable? _____

Do you have dental insurance? Yes ____ No ____

Who can we thank for you seeing us today? _____

HEALTH QUESTIONNAIRE (CONTINUED)

Have you ever been diagnosed with:

Hepatitis	Yes ____ No ____	If female, are you now:	
Rheumatic fever	Yes ____ No ____	Pregnant	Yes ____ No ____
Kidney disease	Yes ____ No ____	Taking anti-pregnancy drug	Yes ____ No ____
Diabetes	Yes ____ No ____	Cancer	Yes ____ No ____
Tuberculosis	Yes ____ No ____	Frequent headaches	Yes ____ No ____
Heart trouble	Yes ____ No ____	Frequent urination	Yes ____ No ____
Heart murmur	Yes ____ No ____	Depression	Yes ____ No ____
High blood pressure	Yes ____ No ____	Unusual weight change	Yes ____ No ____
Shortness of breath	Yes ____ No ____	Joint replacement	Yes ____ No ____
Chest pains	Yes ____ No ____	Heart valve replacement	Yes ____ No ____
Radiation treatment	Yes ____ No ____	Prolonged bleeding after injury	Yes ____ No ____
HIV/AIDS	Yes ____ No ____	Bleeding gums	Yes ____ No ____
Glaucoma	Yes ____ No ____	Receding gums	Yes ____ No ____
Ulcers/Stomach trouble	Yes ____ No ____	Grinding/Clenching	Yes ____ No ____
Thyroid/Parathyroid trouble	Yes ____ No ____	Loose teeth	Yes ____ No ____
Epilepsy	Yes ____ No ____	TMJ problems	Yes ____ No ____
Surgery	Yes ____ No ____	Shifting teeth	Yes ____ No ____
Drug reaction	Yes ____ No ____	Implants	Yes ____ No ____
Liver disease	Yes ____ No ____	Past periodontal treatment	Yes ____ No ____
Low blood pressure	Yes ____ No ____	Past orthodontic treatment	Yes ____ No ____

Other dental history _____

Are you pleased with the appearance of your teeth? Yes ____ No ____

If not, what would you like to improve? _____

Are you presently under the care of a physician? Yes ____ No ____

If so, why? _____

Are you taking any medications now? Yes ____ No ____

If so, what? (dose and frequency) _____

Have you taken medication regularly within the last year? Yes ____ No ____

If so, what? _____

Allergies _____

Do you smoke or use tobacco products? Yes ____ No ____

If so, what and what frequency _____

I hereby certify that the above information is correct and that I have not withheld any information or medications. I understand that insurance may not cover all costs of treatment and I agree to pay my balance, 1.5% interest per month, and/or all costs of collection incurred by David Wickness, DMD. A $25.00 fee is charged for appointments canceled or broken without 24 hours advance notice.

Signature _____ Date _____