



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 \$50.00 fee is charged for appointments canceled or broken without 24 hours advance notice.

Signature _____ Date _____