JOSEPH S. GAY, D.D.S.

Patient Questionnaire

Date _____

Name_____Address_____

City_____ State _____ Zip _____Home Phone ( ) _____

Work Phone ( ) _____Cell ( ) _____Email_____

Sex (M/F) _____ Marital Status (S/M/W) Date of birth_____

Social Security #_____Occupation _____Employer_____

Insurance Y/N Insurance Company _____Phone # ( ) _____

Referred by _____

Does your medical history include any of the following?

Any heart problems Yes___No___

High blood pressure Yes___No___

Circulatory problems Yes ___No___

Nervous problems Yes___No___

Radiation treatments Yes___No___

Allergies to medications or drugs _____If yes, what? _____

Allergies to anesthetics Yes___No___

Allergies to anything else? _____If yes, what? _____

Anemia Yes ___No___

Arthritis Yes ___No___

Asthma Yes ___No___

Diabetes Yes ___No___

Hepatitis Yes ___No___

Cancer Yes ___No___

Childhood diseases ___If yes, which ones? _____

Psychiatric care Yes___No___

Rheumatic fever Yes ___No___

Scarlet fever Yes ___No__

Sinus problems Yes ___No___

Stroke Yes ___No___

Typhoid fever Yes ___No___

Tonsillitis Yes ___No___

Tuberculosis Yes ___No___

Ulcer Yes ___No___

Venereal disease Yes___No___

Any other medical conditions? _____If yes, what? _____

Are you pregnant? ___If yes, how far along are you? _____Your doctor is

Dr._____Phone # ( ) _____

List any drugs you are presently taking_____

_____

Pharmacy name _____Phone # ( ) _____

In case of emergency, whom do we notify? _____Phone# ( ) ___

Patient or Guardian's signature _____