GO! DENTAL SERVICES
PATIENT INFORMATION QUESTIONNAIRE

Welcome to the Go! Dental Services family. We are very grateful for the opportunity to assist you in the supervision and maintenance of your oral health. Consider us at your service.

Your initial visit will be primarily concerned with the identification and evaluation of your personal dental health. This generally includes a comprehensive examination, cleaning, and x-rays. If you're in pain and have an immediate dental need you would like addressed, please let us know.

Patient Information:

Patient's Name: (Last) _____ (MI) ___ (First) _____

I prefer to be called: _____ Marital Status: ☐Single ☐Married ☐Divorced ☐Other

DOB: _____ /_____ /_____ Gender: ☐Male ☐Female

Community of residence: _____

Phone Number: (_____) _____

E-mail Address: _____

Reason for today's visit: _____

Responsible Party's Information: (Only fill out if patient is not responsible for their own account)

(Last)_____(MI)_____(First)_____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone Number (_____) _____Business Number: (_____) _____

Mobile Phone Number (_____) _____Other (_____) _____

E-mail Address: _____

Relationship to Patient: _____

Please contact me before any treatment is started: ☐Yes ☐No

Emergency Contact Information (to be filled out if different from above, or patient has no responsible party):

Name: (Last)_____(MI)_____(First)_____

Daytime Number: (_____)_____Evening Number: (_____)_____

Address: _____ City: _____ State: _____ Zip: _____

Relationship to Patient: _____

Completed By:_____ **Date:**_____

Staff Position: _____

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Resident Name: _____ **Community:** _____

Medical History

Are you allergic to any of the following?

☐Yes ☐No Aspirin
☐Yes ☐No Ibuprophen
☐Yes ☐No Acetaminophen
☐Yes ☐No Penicillin/Amoxicillin
☐Yes ☐No Erythromycin
☐Yes ☐No Tetracycline
☐Yes ☐No Codeine
☐Yes ☐No Local Anesthetics
☐Yes ☐No Fluoride
☐Yes ☐No Metals (gold/stainless steel/other)
☐Yes ☐No Latex
☐Yes ☐No Any other medication _____

☐Yes ☐No **Are you required to take pre-medication before dental treatment? If yes, for what condition**_____

Name of Physician_____
Physician Phone #: _____
Most recent Physical_____

☐Yes ☐No **Recent hospitalizations?**
Why? _____

List any medication, herbal supplements, and or vitamins taken within the last two years:

_____
_____
_____
_____

Please describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment:

_____
_____
_____
_____

Completed By: _____

Staff Position: _____

Do you have any of the following conditions?

☐Yes ☐No Heart problems
☐Yes ☐No Defibrillator or Pacemaker
☐Yes ☐No Artificial Heart Valve(s)
☐Yes ☐No Heart murmur
☐Yes ☐No Rheumatic fever
☐Yes ☐No High blood pressure
☐Yes ☐No Low blood pressure
☐Yes ☐No Artificial joints
If yes, what type? _____
Date Placed: _____
☐Yes ☐No Anemia
☐Yes ☐No Prolonged bleeding due to slight cut
☐Yes ☐No Emphysema
☐Yes ☐No Tuberculosis
☐Yes ☐No Asthma
☐Yes ☐No Sinus problems
☐Yes ☐No Kidney disease or dialysis
☐Yes ☐No Liver disease
☐Yes ☐No Thyroid or parathyroid disease
☐Yes ☐No Osteoporosis
☐Yes ☐No Arthritis
☐Yes ☐No Glaucoma
☐Yes ☐No Diabetes
☐Yes ☐No Stomach or duodenal ulcer
☐Yes ☐No Digestive disorders
☐Yes ☐No Epilepsy or convulsions (seizures)
☐Yes ☐No Hepatitis (type_____)
☐Yes ☐No HIV/AIDS
☐Yes ☐No Radiation therapy
☐Yes ☐No Chemotherapy
☐Yes ☐No Medical Ports
☐Yes ☐No Tumor or abnormal growth
☐Yes ☐No Any lumps or swelling in the mouth
☐Yes ☐No Alcohol or drug dependency
☐Yes ☐No Psychiatric treatment
☐Yes ☐No Antidepressant medication
☐Yes ☐No Are you presently being treated for any illness?
☐Yes ☐No Subject to frequent headache
☐Yes ☐No Heavy smoker (1or more packs a day)
☐Yes ☐No Head or neck injuries

Date: _____