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:

____

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____

____

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

____

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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

Completed By: ____________________________________

Staff Position: ____________________________________

Date: ____

1.800.715.9211 www.Go-DentalServices.com