Tel: 954-763-3358
Fax: 954-728-9999
1209 W Broward Blvd.
Fort Lauderdale, FL 33312

Dental Health Questionnaire

How did you hear about Broward DDS Michael Barnard and Associates? ______________________

Name
Employer
Address
Occupation
City
State
Zip Code
Sex:
Date Of Birth
Telephone
Marital Status:
Age:
Email
SSN
Driver License / ID

Insured Name
Insured Social Security #
Insuranc Co.:
Group #
Plan #
Insuranc Co. Telephone:

Patients Name
Sex:
Date Of Birth
Address
Marital Status:
Age:
City
State
Zip Code
Home Tel:
Cell :
Email
SSN
Driver License / ID

House Hold Family Members and Relationship

Emergency Information (Nearest Relative or Neighbor

Name
Telephone
Address
City
Zip Code

Tel: 954-763-3358
Fax: 954-728-9999

1209 W Broward Blvd.
Fort Laurderale, FL 33312

BrowardDDS
Michael Barnard & Associates
Ft Lauderdale Dentist

Medical History

Physicians Name ____________ Telephone ____________

Address ____________ City ____________ Zip Code ____________

Are You Allergic to? (Check Box If Yes)

☐ Latex ☐ Penicillin ☐ Aspirin ☐ Codeine ☐ Novacaine ☐ None ☐ Other ____________

Are You Presently Taking Any Medications Or Drugs? ☐ YES ☐ NO

List Any Medications ____________ ____________ ____________ ____________

Have You Recently Been Hospitalized: If So For What? ____________

Are You Pregnant? ☐ YES ☐ NO Due Date ____________

Do You Bleed Excessively? ☐ YES ☐ NO Do You Have Shortness Of Breath Frequently? ☐ YES ☐ NO

Do You Work With Or Are you Exposed To X-Rays Freq? ☐ YES ☐ NO

Have You Ever Had (Please Date)		Date			Date
Rheumatic Fever	☐ Y ☐ N	______	Tuberculosis	☐ Y ☐ N	______
Heart Murmer	☐ Y ☐ N	______	Diabetes	☐ Y ☐ N	______
High Blood Pressure	☐ Y ☐ N	______	Sinus Trouble	☐ Y ☐ N	______
Heart Attack (Angina)	☐ Y ☐ N	______	Cancer or Tumor	☐ Y ☐ N	______
Mitral Valve Prolapse	☐ Y ☐ N	______	Lung Disease(Asthma)	☐ Y ☐ N	______
Pace Maker	☐ Y ☐ N	______	Arthritis	☐ Y ☐ N	______
Hepatitis	☐ Y ☐ N	______	Epilepsy	☐ Y ☐ N	______
HIV (AIDS)	☐ Y ☐ N	______	Kidney Disease	☐ Y ☐ N	______
Hip or Knee Replaced	☐ Y ☐ N	______	Hemophilia (Bleeding)	☐ Y ☐ N	______
Nervous Breakdown	☐ Y ☐ N	______	Drug Addiction	☐ Y ☐ N	______

List Any Other Disease or Physical Condition Not Listed Above ____________

Tel: 954-763-3358
Fax: 954-728-9999
1209 W Broward Blvd.
Fort Laurderale, FL 33312

BrowardDDS
Michael Barnard & Associates
Ft Lauderdale Dentist

Dental History

How Long Since Your Last Dental Visit Or X-rays (Date)? ____________________

Are You Having Any Dental Problems Today? ☐ Y ☐ N

Do You Have A Painfull Jaw or Headaches? ☐ Y ☐ N

Do You Have Bleeding Or Sore Gums? ☐ Y ☐ N

Do You Have A Toothache? ☐ Y ☐ N

Do You Wear Dentures (plates) - Partial or Full ? ☐ Y ☐ N

Are You Unhappy With Your Dentures? ☐ Y ☐ N

Do You Have Any Missing Teeth? ☐ Y ☐ N

Would You Like To Know More About Permanent Replacements? ☐ Y ☐ N

Are You Unhappy With The APPEARANCE Of Your Teeth? ☐ Y ☐ N

Do You Have Twisted Or Crooked Teeth? ☐ Y ☐ N

Do You Have Stained Or Discolored Teeth? ☐ Y ☐ N

Would You Like Your Smile To LOOK BETTER or DIFFERENT? ☐ Y ☐ N

Would You Like WHITER teeth ☐ Y ☐ N

Would You Like to be Computer Imaged ☐ Y ☐ N

(Imaging is a computer program that takes a picture of your mouth and changes it to any desirable shape, color or smile that you would like and show. We Then show you what we can do for your smile on the screen before and after for no charge.)

Main Reason For Your Visit Today? ____________________

Appointments Cancelled less than 24 hours in advance will be subject to a penalty payment

We Help you by filing your insurance, any balance not paid by inusrance is your responsibility

Doctor Signature	Date	Print Form	Patient Signature (Parent or Guardian, if Minor)	Date