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

1209 W Broward Blvd.
Fort Lauderdale, FL 33312

Broward DDS
Michael Barnard & Associates
Ft Lauderdale Dentist

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

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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 _____

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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** Patient Signature (Parent or Gauradian, if Minor) Date