

CONFIDENTIAL PATIENT INFORMATION

| | | | | |
|--|--------------------------------------|--------|---------------------------------|---|
| PATIENT'S NAME | | | DATE OF BIRTH (MM/DD/YY) | Gender |
| Last | First | Middle | | <input type="checkbox"/> F <input type="checkbox"/> M |
| PATIENT'S ADDRESS | | | Home Phone # | Cell phone # |
| | | | Work Phone # | |
| By which way do you prefer to communicate with us? (Check more than one choices if necessary) | | | | |
| <input type="checkbox"/> Home # <input type="checkbox"/> Cell # <input type="checkbox"/> Work # <input type="checkbox"/> Text <input type="checkbox"/> Email | | | | |
| MARITAL STATUS | PATIENT'S/GUARDIAN'S EMPLOYER | | OCCUPATION | |

EMAIL ADDRESS (Your email address will be in confidence and only used for office communication with you)

| | | | | |
|----------------------|-------|--------|--------------------------|-------------------|
| SPOUSE'S NAME | | | SPOUSE'S EMPLOYER | OCCUPATION |
| Last | First | Middle | | |

PERSON WE CAN CONTACT IN CASE OF EMERGENCY (OTHER THAN YOUR FAMILY HOME)

| | | | |
|--------------|----------------------|-----------------|-----------------|
| NAME: | RELATIONSHIP: | WORK NO. | HOME NO. |
|--------------|----------------------|-----------------|-----------------|

HOW DID YOU HEAR ABOUT US?

- FRIENDS/FAMILY** (Please Name so we can thank them :___) **Internet (Website, facebook)** **Drive- By**
 Phonebook (please name if known: _____) **Newspaper** (please name if known: _____)

INSURANCE AND FINANCIAL INFORMATION

| | | | | | |
|--|--|--|--|---|--|
| INSURANCE COVERAGE | | INSURANCE COMPANY NAME | | INSURANCE ADDRESS | |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | |
| SUBSCRIBER'S NAME (If different from above) | | PATIENT'S RELATIONSHIP TO SUBSCRIBER | | SUBSCRIBER D.O.B (If different from above) | |
| | | <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE/COMMONLAW <input type="checkbox"/> DEPENDENT | | | |
| Group Number AND ID Number | | EMPLOYER | | EMPLOYER'S ADDRESS | |
| | | | | | |
| SECONDARY INSURANCE COVERAGE | | 2nd INSURANCE COMPANY NAME | | 2nd INSURANCE ADDRESS | |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | |
| SUBSCRIBER'S NAME (If different from above) | | PATIENT'S RELATIONSHIP TO SUBSCRIBER | | SUBSCRIBER D.O.B (If different from above) | |
| | | <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE/COMMONLAW <input type="checkbox"/> DEPENDENT | | | |
| GROUP/PROGRAM NUMBER | | EMPLOYER (If different from above) | | EMPLOYER'S ADDRESS | |
| | | | | | |

GENERAL RELEASE

I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information. I have had the opportunity to ask any questions and receive answers to any questions regarding my medical-dental history. I realize that the dentist is a general practitioner who offers many specialized treatments to patients. Should there be any change in my health status in the future, I will advise this dental office.

I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my doctor or another health care provider may be necessary.

I consent to the responsibility for payment of the dental services for myself and my dependents is mine solely and I assume responsibility for fees associated with these services. I understand this office requires **24 hour** notification to avoid any minimum charges.

Patient's or Guardian's Signature _____ **Date** _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? Excellent Good Fair Poor

DO YOU HAVE or HAVE YOU EVER HAD:

| | YES | NO | | YES | NO |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. hospitalization for illness or injury _____ | <input type="checkbox"/> | <input type="checkbox"/> | 26. osteoporosis/osteopenia (i.e. taking bisphosphonates) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. an allergic reaction to _____ | | | 27. arthritis, rheumatoid arthritis, lupus _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> aspirin, ibuprofen, acetaminophen, codeine | | | 28. glaucoma _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> penicillin | | | 29. contact lenses _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> erythromycin | | | 30. head or neck injuries _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> tetracycline | | | 31. epilepsy, convulsions (seizures) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> sulfa | | | 32. neurologic disorders (ADD/ADHD, prion disease) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> local anesthetic | | | 33. viral infections and cold sores _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> fluoride | | | 34. any lumps or swelling in the mouth _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> metals (nickel, gold, silver, _____) | | | 35. hives, skin rash, hay fever _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> latex | | | 36. STI / STD _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> other _____ | | | 37. hepatitis (type _____) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. heart problems, or cardiac stent within the last six months _____ | <input type="checkbox"/> | <input type="checkbox"/> | 38. HIV / AIDS _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. history of infective endocarditis _____ | <input type="checkbox"/> | <input type="checkbox"/> | 39. tumor, abnormal growth _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. artificial heart valve, repaired heart defect (PFO) _____ | <input type="checkbox"/> | <input type="checkbox"/> | 40. radiation therapy _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. pacemaker or implantable defibrillator _____ | <input type="checkbox"/> | <input type="checkbox"/> | 41. chemotherapy, immunosuppressive _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. artificial prosthesis (heart valve or joints) _____ | <input type="checkbox"/> | <input type="checkbox"/> | 42. emotional problems _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. rheumatic or scarlet fever _____ | <input type="checkbox"/> | <input type="checkbox"/> | 43. psychiatric treatment _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. high or low blood pressure _____ | <input type="checkbox"/> | <input type="checkbox"/> | 44. antidepressant medication _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. a stroke (taking blood thinners) _____ | <input type="checkbox"/> | <input type="checkbox"/> | 45. excessive alcohol / street drug use _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. anemia or other blood disorder _____ | <input type="checkbox"/> | <input type="checkbox"/> | ARE YOU: | | |
| 12. prolonged bleeding due to a slight cut (INR > 3.5) _____ | <input type="checkbox"/> | <input type="checkbox"/> | 46. presently being treated for any other illness _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. emphysema, shortness of breath, sarcoidosis _____ | <input type="checkbox"/> | <input type="checkbox"/> | 47. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. tuberculosis, measles, chicken pox _____ | <input type="checkbox"/> | <input type="checkbox"/> | 48. taking medication for weight management (i.e. fen-phen) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. asthma _____ | <input type="checkbox"/> | <input type="checkbox"/> | 49. taking dietary supplements _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus) _____ | <input type="checkbox"/> | <input type="checkbox"/> | 50. often exhausted or fatigued _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. kidney disease _____ | <input type="checkbox"/> | <input type="checkbox"/> | 51. experiencing frequent headaches _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. liver disease _____ | <input type="checkbox"/> | <input type="checkbox"/> | 52. a smoker, smoked previously or use smokeless tobacco _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. jaundice _____ | <input type="checkbox"/> | <input type="checkbox"/> | 53. considered a touchy person _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. thyroid, parathyroid disease, or calcium deficiency _____ | <input type="checkbox"/> | <input type="checkbox"/> | 54. often unhappy or depressed _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. hormone deficiency _____ | <input type="checkbox"/> | <input type="checkbox"/> | 55. FEMALE - taking birth control pills _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. high cholesterol or taking statin drugs _____ | <input type="checkbox"/> | <input type="checkbox"/> | 56. FEMALE - pregnant _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. diabetes (HbA1c = _____) | <input type="checkbox"/> | <input type="checkbox"/> | 57. MALE - prostate disorders _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. stomach or duodenal ulcer _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 25. digestive disorders (i.e. celiac disease, gastric reflux) _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

List all medications, supplements, and or vitamins taken within the last two years

| Drug | Purpose | Drug | Purpose |
|------|---------|------|---------|
| | | | |
| | | | |
| | | | |

Ask for an additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Office Use Only: Blood Pressure: / Pulse: 

DENTAL HISTORY

Name _____ Nickname _____ Age _____
Referred by _____ How would you rate the condition of your mouth? Excellent Good Fair Poor
Previous Dentist _____ How long have you been a patient? _____ Months/Years
Date of most recent dental exam ____/____/____ Date of most recent x-rays ____/____/____
Date of most recent treatment (other than a cleaning) ____/____/____
I routinely see my dentist every: 3 mo. 4 mo. 6 mo. 12 mo. Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

YES NO

PERSONAL HISTORY



1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____ YES NO
2. Have you had an unfavorable dental experience? _____ YES NO
3. Have you ever had complications from past dental treatment? _____ YES NO
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ YES NO
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ YES NO
6. Have you had any teeth removed? _____ YES NO

GUM AND BONE



7. Do your gums bleed or are they painful when brushing or flossing? _____ YES NO
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ YES NO
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____ YES NO
10. Is there anyone with a history of periodontal disease in your family? _____ YES NO
11. Have you ever experienced gum recession? _____ YES NO
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ YES NO
13. Have you experienced a burning sensation in your mouth? _____ YES NO

TOOTH STRUCTURE



14. Have you had any cavities within the past 3 years? _____ YES NO
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ YES NO
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ YES NO
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____ YES NO
18. Do you have grooves or notches on your teeth near the gum line? _____ YES NO
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ YES NO
20. Do you frequently get food caught between any teeth? _____ YES NO

BITE AND JAW JOINT



21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ YES NO
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? _____ YES NO
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____ YES NO
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ YES NO
25. Are your teeth crowding or developing spaces? _____ YES NO
26. Do you have more than one bite and squeeze to make your teeth fit together? _____ YES NO
27. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ YES NO
28. Do you clench your teeth in the daytime or make them sore? _____ YES NO
29. Do you have any problems with sleep or wake up with an awareness of your teeth? _____ YES NO
30. Do you wear or have you ever worn a bite appliance? _____ YES NO

SMILE CHARACTERISTICS



31. Is there anything about the appearance of your teeth that you would like to change? _____ YES NO
32. Have you ever whitened (bleached) your teeth? _____ YES NO
33. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ YES NO
34. Have you been disappointed with the appearance of previous dental work? _____ YES NO

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____