PATIENT INFORMATION

What can we do for you? _____ Date _____

Patient's Name: _____ Sex M F D.O.B. ____/____/____

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

Home Phone: _____ Work Phone: _____ Cell Phone: _____ Email: _____

Employer: _____ Occupation: _____ Spouse, Parent, Guardian, S.O. _____

How did you hear about us?: _____

MEDICAL HISTORY

Family Physician and Address: _____ Last Physical Exam ____/__/____

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury	☐	☐
2. allergies (drugs or environmental)	☐	☐
3. heart problems, or cardiac stent w/in the last 6 months	☐	☐
4. history of infective endocarditis	☐	☐
5. artificial heart valve, repaired heart defect (PFO)	☐	☐
6. pacemaker or implantable defibrillator	☐	☐
7. artificial prosthesis (heart valve or joints)	☐	☐
8. rheumatic or scarlet fever	☐	☐
9. high or low blood pressure	☐	☐
10. a stroke (taking blood thinners)	☐	☐
11. anemia or other blood disorder	☐	☐
12. prolonged bleeding due to a slight cut (INR > 2.4)	☐	☐
13. emphysema, sarcoidosis (supplemental oxygen)	☐	☐
14. tuberculosis:	☐	☐
15. asthma, (how often use an inhaler?)	☐	☐
16. breathing or sleep problems (i.e. snoring, sinus)	☐	☐
17. kidney disease	☐	☐
18. liver disease	☐	☐
19. jaundice	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency	☐	☐
21. hormone deficiency	☐	☐
22. high cholesterol or taking statin drugs	☐	☐
23. diabetes (HbA1c =_____)	☐	☐
24. stomach or duodenal ulcer	☐	☐
25. digestive disorders (i.e. gastric reflux)	☐	☐
26. osteoporosis/osteopenia (i.e. taking bisphosphonates)	☐	☐
27. arthritis	☐	☐
28. glaucoma (narrow angle / wide angle)	☐	☐
29. contact lenses	☐	☐
30. head or neck injuries	☐	☐
31. epilepsy, (seizures) weekly, monthly, yearly	☐	☐
32. neurologic problems (attention deficit disorder)	☐	☐
33. viral infections and cold sores	☐	☐
34. any lumps or swelling in the mouth	☐	☐
35. venereal disease or herpes	☐	☐
36. hepatitis (type ___)	☐	☐
37. HIV / AIDS	☐	☐
38. sleep study for Sleep Apnea, AHI:	☐	☐
39. using CPAP for Sleep Apnea	☐	☐
40. radiation therapy	☐	☐
41. chemotherapy	☐	☐
42. emotional problems	☐	☐
43. psychiatric treatment	☐	☐
44. antidepressant medication	☐	☐
45. alcohol / recreational drugs	☐	☐
ARE YOU:		
46. presently being treated for any other illness	☐	☐
47. aware of a change in your general health	☐	☐
48. taking medication for weight management	☐	☐
49. taking dietary supplements	☐	☐
50. often exhausted or fatigued	☐	☐
51. subject to frequent headaches	☐	☐
52. smoke or use tobacco products	☐	☐
53. considered particular	☐	☐
54. often unhappy or depressed	☐	☐
55. FEMALE - taking birth control pills	☐	☐
56. FEMALE – pregnant	☐	☐
57. MALE – prostate disorders	☐	☐

Comments: _____

_____

_____

List all medications, supplements, and or vitamins taken within the last 2 years.

Drug (dosage)	Purpose	Drug (dosage)	Purpose

Patient Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

ASA I II III IV

DENTAL HISTORY

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) [____] _____ ☐ ☐
2. Have you had an unfavorable dental experience? _____ ☐ ☐
3. Have you ever had complications from past dental treatment? _____ ☐ ☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ ☐ ☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ ☐ ☐
6. Have you had any teeth removed? _____ ☐ ☐

SMILE CHARACTERISTICS

7. Is there anything about the appearance of your teeth that you would like to change? _____ ☐ ☐
8. Have you ever whitened (bleached) your teeth? _____ ☐ ☐
9. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ ☐ ☐
10 Have you been disappointed with the appearance of previous dental work? _____ ☐ ☐

BITE AND JAW JOINT

11. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ ☐ ☐
12. Do you / would you have any problems chewing gum? _____ ☐ ☐
13. Do you / would you have any problems chewing bagels, baguettes , protein bars, or other hard foods? _____ ☐ ☐
14. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ ☐ ☐
15. Are your teeth crowding or developing spaces? _____ ☐ ☐
16. Do you have more than one bite and squeeze to make your teeth fit together? _____ ☐ ☐
17. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ ☐ ☐
18. Do you clench your teeth in the daytime or make them sore? _____ ☐ ☐
19. Do you have any problems with sleep or wake up with an awareness of your teeth? _____ ☐ ☐
20. Do you wear or have you ever worn a bite appliance? _____ ☐ ☐

TOOTH STRUCTURE

21. Have you had any cavities within the past 3 years? _____ ☐ ☐
22. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ ☐ ☐
23. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ ☐ ☐
24. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____ ☐ ☐
25. Do you have grooves or notches on your teeth near the gum line? _____ ☐ ☐
26. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ ☐ ☐
27. Do you get food caught between any teeth? _____ ☐ ☐

GUM AND BONE

28. Do your gums bleed when brushing or flossing? _____ ☐ ☐
29. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ ☐ ☐
30. Have you ever noticed an unpleasant taste or odor in your mouth? _____ ☐ ☐
31. Is there anyone with a history of periodontal disease in your family? _____ ☐ ☐
32. Have you ever experienced gum recession? _____ ☐ ☐
33. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ ☐ ☐
34. Have you experienced a burning sensation in your mouth? _____ ☐ ☐

Patient's Signature _____ Date_____

Doctor's Signature _____ Date _____