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) [____] _____ ☐ ☐
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 or missing teeth that never developed? _____ ☐ ☐

GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing? _____ ☐ ☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ ☐ ☐
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____ ☐ ☐
10. Is there anyone with a history of periodontal disease in your family? _____ ☐ ☐
11. Have you ever experienced gum recession? _____ ☐ ☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ ☐ ☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? _____ ☐ ☐

TOOTH STRUCTURE

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

BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ ☐ ☐
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? _____ ☐ ☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____ ☐ ☐
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ ☐ ☐
25. Are your teeth becoming more crooked, crowded, or overlapped? _____ ☐ ☐
26. Are your teeth developing spaces or becoming more loose? _____ ☐ ☐
27. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together? _____ ☐ ☐
28. Do you place your tongue between your teeth or close your teeth against your tongue? _____ ☐ ☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ ☐ ☐
30. Do you clench your teeth in the daytime or make them sore? _____ ☐ ☐
31. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth? _____ ☐ ☐
32. Do you wear or have you ever worn a bite appliance? _____ ☐ ☐

SMILE CHARACTERISTICS

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

Patient's Signature _____ Date_____
Doctor'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
1. hospitalization for illness or injury_____	☐	☐
2. an allergic reaction to _____	☐	☐
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfa		
☐ local anesthetic		
☐ fluoride		
☐ metals (nickel, gold, silver, _____)		
☐ latex		
☐ other _____	☐	☐
3. heart problems, or cardiac stent within the last six months __	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. orthopedic implant (joint replacement)_____	☐	☐
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 > 3.5) _____	☐	☐
13. emphysema, shortness of breath, sarcoidosis _____	☐	☐
14. tuberculosis, measles, chicken pox_____	☐	☐
15. asthma _____	☐	☐
16. breathing or sleep problems (i.e. sleep apnea, 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. celiac disease, gastric reflux) _____	☐	☐
26. osteoporosis/osteopenia (i.e. taking bisphosphonates)_____	☐	☐

	YES	NO
27. arthritis _____	☐	☐
28. autoimmune disease _____	☐	☐
(i.e. rheumatoid arthritis, lupus, scleroderma)		
29. glaucoma _____	☐	☐
30. contact lenses _____	☐	☐
31. head or neck injuries _____	☐	☐
32. epilepsy, convulsions (seizures) _____	☐	☐
33. neurologic disorders (ADD/ADHD, prion disease) _____	☐	☐
34. viral infections and cold sores _____	☐	☐
35. any lumps or swelling in the mouth_____	☐	☐
36. hives, skin rash, hay fever_____	☐	☐
37. STI / STD / HPV _____	☐	☐
38. hepatitis (type ___) _____	☐	☐
39. HIV / AIDS _____	☐	☐
40. tumor, abnormal growth_____	☐	☐
41. radiation therapy_____	☐	☐
42. chemotherapy, immunosuppressive medication _____	☐	☐
43. emotional difficulties_____	☐	☐
44. psychiatric treatment_____	☐	☐
45. antidepressant medication _____	☐	☐
46. alcohol / recreational drug use _____	☐	☐
ARE YOU:		
47. presently being treated for any other illness _____	☐	☐
48. aware of a change in your health in the last 24 hours		
(i.e. fever, chills, new cough, or diarrhea) _____	☐	☐
49. taking medication for weight management _____	☐	☐
50. taking dietary supplements _____	☐	☐
51. often exhausted or fatigued _____	☐	☐
52. experiencing frequent headaches_____	☐	☐
53. a smoker, smoked previously or use smokeless tobacco _	☐	☐
54. considered a touchy / sensitive person _____	☐	☐
55. often unhappy or depressed_____	☐	☐
56. taking birth control pills _____	☐	☐
57. currently pregnant _____	☐	☐
58. prostate disorders _____	☐	☐

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

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 _____

ASA _____ (1-6)

CONFIDENTIAL INFORMATION QUESTIONNAIRE

Please Print

PATIENT'S NAME LAST	FIRST	MIDDLE	SEX	DATE OF BIRTH

SOCIAL SECURITY NUMBER	HOME PHONE	CELL PHONE	EMAIL

PATIENT'S ADDRESS STREET	APT #	CITY	STATE	ZIP

MARITAL STATUS ❑ M ❑ S ❑ D ❑ W ❑ UNDER AGE 18	PATIENT'S/GUARDIAN'S EMPLOYER	OCCUPATION

WORK ADDRESS STREET	CITY	STATE ZIP	WORK PHONE OK TO CALL WORK ❑ YES ❑ NO

SPOUSE'S NAME LAST	FIRST	MIDDLE	SPOUSE'S EMPLOYER	OCCUPATION

WORK ADDRESS STREET	CITY	STATE ZIP	WORK PHONE OK TO CALL WORK ❑ YES ❑ NO

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

NAME	RELATIONSHIP	WORK #	HOME #

OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE	WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE

INSURANCE AND FINANCIAL INFORMATION

INSURANCE COVERAGE ❑ YES ❑ NO	INSURANCE COMPANY NAME	ADDRESS	PHONE

SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER ❑ SELF ❑ SPOUSE ❑ DEPENDENT	SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SSN

GROUP/PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)	EMPLOYER ADDRESS

SECONDARY COVERAGE ❑ YES ❑ NO	INSURANCE COMPANY NAME	ADDRESS	PHONE

SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER ❑ SELF ❑ SPOUSE ❑ DEPENDENT	SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SSN

GROUP/PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)	EMPLOYER ADDRESS

ASSIGNMENT & RELEASE:

I hereby authorize my insurance benefits to be paid directly to the dentists. I am financially responsible for any balances due and authorize the dentists to release any information for this claim. I authorize that my records can be used by the doctor if he so determines.

In consideration of the services rendered to me by this dental office I am obligated to pay said office in accordance with its credit terms and policy.

I consent to the making of videotapes, photographs, and x-rays before, during, and after treatment, and to the use of same by the doctor in scientific papers or demonstrations.

I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

Signature _____ Date_____