

PATIENT INFORMATION

FIRST NAME: _____ INITIAL: _____ LAST NAME: _____

ADDRESS: _____

CITY: _____ PROVINCE: _____ POSTAL CODE: _____

BIRTHDATE (D/M/Y): _____ OCCUPATION: _____ EMPLOYER: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

EMAIL ADDRESS: _____ GENDER (M/F): _____

EMERGENCY CONTACT NAME: _____ RELATIONSHIP: _____ PHONE: _____

PHYSICIAN NAME: _____ PHONE: _____ HEALTH CARE NUMBER: _____

PATIENT INFORMATION

PRIMARY INSURANCE PLAN

HOLDER'S FULL NAME: _____ BIRTHDATE (D/M/Y): _____

NAME OF INSURANCE CO.: _____

GROUP/PLAN NUMBER: _____ CERTIFICATE/ID NUMBER: _____

SECONDARY INSURANCE PLAN

HOLDER'S FULL NAME: _____ BIRTHDATE (D/M/Y): _____

NAME OF INSURANCE CO.: _____

GROUP/PLAN NUMBER: _____ CERTIFICATE/ID NUMBER: _____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

IS ANOTHER FAMILY MEMBER A PATIENT IN OUR OFFICE? _____

PATIENT 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? _____ MOS/YRS

DATE OF MOST RECENT DENTAL EXAM: ____/____/____ DATE OF MOST RECENT X-RAYS: ____/____/____

DATE OF MOST RECENT TREATMENT (OTHER THAN CLEANING) ____/____/____

I ROUTINELY SEE MY DENTIST EVERY: 3 MO. 6 MO. 12 MO. NOT ROUTINELY

WHAT IS YOUR IMMEDIATE CONCERN? _____

ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY

YES NO

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, and at what age? _____
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma? _____

GUM AND BONE

YES NO

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

YES NO

14. Have you had any cavities within the past 3 years? _____
15. Does the amount of saliva in your mouth seem to 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 do you 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

YES NO

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 try to bite your back teeth together? _____
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? _____
25. Are your teeth becoming more crooked, crowded, or overlapped? _____
26. Are your teeth developing spaces or becoming more loose? _____
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, 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 or grind your teeth together in the daytime or make them sore? _____
31. Do you have any problems with sleep (i.e. restless or teeth grinding), 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

YES NO

33. Is there anything about the appearance of your teeth that you would like to change? (shape, color, size)? _____
34. Have you ever whitened (bleached) your teeth? _____
35. Have you ever felt comfortable 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: _____

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 (e.g., taking bisphosphonates) | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. An allergic or bad reaction to any of the following: | <input type="checkbox"/> | <input type="checkbox"/> | 27. Arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Aspirin, ibuprofen, acetaminophen, codeine | | | 28. Autoimmune disease (e.g. rheumatoid arthritis, lupus, scleroderma) | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Penicillin | | | 29. Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Erythromycin | | | 30. Contact lenses | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Tetracycline | | | 31. Head and neck injuries | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Sulfa | | | 32. Epilepsy, convulsions (seizures) | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Local anesthetic | | | 33. Neurologic disorders (ADD/ADHD, prion disease) | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Fluoride | | | 34. Viral infections and cold sores | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Chlorhexidine (CHX) | | | 35. Any lumps or swelling in the mouth | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Metals (nickel, gold, silver, _____) | | | 36. Hives, skin rash, hay fever | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Latex _____ | | | 37. STI/STD/HPV | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Nuts _____ | | | 38. Hepatitis (type _____) | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Fruit _____ | | | 39. HIV/AIDS | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Other _____ | | | 40. Tumor, abnormal growth | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Heart problems, or cardiac stent within the last six months | <input type="checkbox"/> | <input type="checkbox"/> | 41. Radiation therapy | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. History of infective endocarditis | <input type="checkbox"/> | <input type="checkbox"/> | 42. Chemotherapy, immunosuppressive medication | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Artificial heart valve, repaired heart defect (PFO) | <input type="checkbox"/> | <input type="checkbox"/> | 43. Emotional difficulties | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Pacemaker or implantable defibrillator | <input type="checkbox"/> | <input type="checkbox"/> | 44. Psychiatric treatment | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Orthopedic implant (joint replacement) | <input type="checkbox"/> | <input type="checkbox"/> | 45. Antidepressant medication | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Rheumatic or scarlet fever | <input type="checkbox"/> | <input type="checkbox"/> | 46. Alcohol/recreational drug use | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. High or low blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | ARE YOU: | YES | NO |
| 10. A stroke (taking blood thinners) | <input type="checkbox"/> | <input type="checkbox"/> | 47. Presently being treated for any other illness | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Anemia or other blood disorder | <input type="checkbox"/> | <input type="checkbox"/> | 48. Aware of a change in your health in the last 24 hours (e.g. fever, chills, new cough, or diarrhea) | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Prolonged bleeding due to a slight cut (INR > 3.5) | <input type="checkbox"/> | <input type="checkbox"/> | 49. Taking medication for weight management | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Pneumonia, emphysema, shortness of breath, sarcoidosis | <input type="checkbox"/> | <input type="checkbox"/> | 50. Taking dietary supplements | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Chronic ear infections, tuberculosis, measles, chicken pox | <input type="checkbox"/> | <input type="checkbox"/> | 51. Often exhausted or fatigued | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Asthma | <input type="checkbox"/> | <input type="checkbox"/> | 52. Experiencing frequent headaches | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Breathing or sleeping problems (e.g. sleep apnea, snoring, sinus) | <input type="checkbox"/> | <input type="checkbox"/> | 53. A smoker, smoked previously or use smokeless tobacco | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Kidney disease | <input type="checkbox"/> | <input type="checkbox"/> | 54. Considered a touchy/sensitive person | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Liver disease | <input type="checkbox"/> | <input type="checkbox"/> | 55. Often unhappy or depressed | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Jaundice | <input type="checkbox"/> | <input type="checkbox"/> | 56. Taking birth control pills | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Thyroid, parathyroid disease, or calcium deficiency | <input type="checkbox"/> | <input type="checkbox"/> | 57. Currently pregnant | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Hormone deficiency | <input type="checkbox"/> | <input type="checkbox"/> | 58. Diagnosed with a prostate disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. High cholesterol or taking statin drugs | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 23. Diabetes (HbA1c=_____) | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 24. Stomach or duodenal ulcer | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 25. Digestive or eating disorders (e.g. celiac disease, gastric reflux, bulimia, anorexia) | <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: _____

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: _____