PATIENT INFORMATION

MEDICAL HISTORY

Dr. Mr. Mrs. Ms. ____ Date of Birth ____/____/____ Marital Status (please circle) S M D W
Social Security Number:_________________________ Employer:____________________________ Spouses Name:_______________________________
Street Address: ____
City: ____ State: _________________________________ Zip Code: _____________________________
Phone (Primary): ___________________ (Work):___________________________ Email: ____
Who may we thank for referring you to our office? ____
General Health: ☐ Excellent ☐ Good ☐ Fair Date of last physical: ____/_____/____
Physician's Name: ____ Phone:____________________________________
Are you under current medical treatment? ☐ Yes ☐ No
If yes, please explain:
____
Are you currently taking any medications? ☐ Yes ☐ No If yes, please list below.
Are you currently taking any vitamins or supplements? ☐ Yes ☐ No If yes, please list below.

Medications:	Dosage/Day:	Reason:

Vitamins/ Supplements:	Dosage/Day:	Reason:

Do you have any allergies or adverse reaction to drugs? ☐Yes ☐No ☐Antibiotics ☐Codeine ☐Local Anesthetic
If yes, please list: ____
Do you use any form of tobacco? ☐Yes ☐No Chew? ☐Yes ☐No Smoke? ☐Yes ☐No
Are you interested in quitting? ☐Yes ☐No
Women only: Are you Pregnant, Nursing, On Hormone Therapy, On Birth Control Medication? *(please circle)*

Do you have or have had any of the following?

Acid Reflux/Heartburn/Cough	☐ Yes	☐ No		HIV or AIDS	☐ Yes	☐ No
Alzheimer's or Dementia	☐ Yes	☐ No		Kidney Disease	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No		Latex Sensitivity	☐ Yes	☐ No
Asthma	☐ Yes	☐ No		Major Surgeries	☐ Yes	☐ No
Bacterial Endocarditis	☐ Yes	☐ No		Migraines	☐ Yes	☐ No
Blood Disorder	☐ Yes	☐ No		Nighttime Snoring	☐ Yes	☐ No
Cancer/ Cancer Treatment	☐ Yes	☐ No		Organ Transplant	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No		Osteoporosis/ Osteopenia	☐ Yes	☐ No
Controlled?	☐ Yes	☐ No		Psychological/ Psychiatric Treatment	☐ Yes	☐ No
Drug/Alcohol Dependency	☐ Yes	☐ No		Prosthetic/Artificial Heart Valve	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No		Pacemaker	☐ Yes	☐ No
Fainting Spells	☐ Yes	☐ No		Respiratory Disease/ COPD	☐ Yes	☐ No
Head Injuries	☐	☐		Rheumatoid Arthritis	☐ Yes	☐ No
Heart Problems	☐ Yes	☐ No		Sinus Problems	☐ Yes	☐ No
Hepatitis or Liver Disease	☐ Yes	☐ No		Sleep Apnea	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No		Stroke	☐ Yes	☐ No
Controlled?	☐ Yes	☐ No		Thyroid Disease	☐ Yes	☐ No
Any other medical problems?						

DENTAL HISTORY

How would you rate the condition of your mouth: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Previous Dentist: ____ How long were you a patient?:_____________________
How often have you routinely seen your dentist: ☐ Every 3 months ☐ Every 4 months ☐ Every 6 months ☐ Every 12 months ☐ Not Routinely
What is your immediate dental concern?
____
Please share with us any other goals or ideas you may have about your oral health or the appearance of your smile:
____

PERSONAL HISTORY (please answer yes or no to each of the following questions)		
1. Are you fearful of dental treatment? If yes, scale of 1-10 (*ten being very fearful*) _____	☐ Yes	☐ No
2. Have you ever had an unfavorable dental experience?	☐ Yes	☐ No
3. Have you ever had trouble getting numb or reacting to local anesthetic?	☐ Yes	☐ No
4. Have you ever had braces or orthodontic treatment?	☐ Yes	☐ No
5. Have you had any teeth removed?	☐ Yes	☐ No
6. Do you have dental implants?	☐ Yes	☐ No
7. Do you wear partial dentures or dentures?	☐ Yes	☐ No
If yes, are you satisfied with the Fit? Function? Appearance?	☐ Yes	☐ No
SMILE CHARACTERISTICS		
8. On a scale of 1-10, how would you rank the appearance of your smile? *(ten being very pleased)* _____		
9. Have you ever whitened (bleached) your teeth?	☐ Yes	☐ No
10. Are you self conscious about your teeth?	☐ Yes	☐ No
11. Have you been disappointed with the appearance of previous dental work?	☐ Yes	☐ No
BITE & JAW JOINT		
12. Do you have any problems chewing hard foods such as bagels or steak?	☐ Yes	☐ No
13. Have your teeth changed in the last 5 years, become shorter, thinner or worn?	☐ Yes	☐ No
14. Are your teeth crowding or developing spaces?	☐ Yes	☐ No
15. Do you have more than one bite, or do you clench (squeeze) to make your teeth fit together?	☐ Yes	☐ No
16. Do you have any problems with sleep in general, or wake up with an awareness of your teeth?	☐ Yes	☐ No
17. Do you have problems with your jaw joint (pain, sounds, limited opening, locking, popping)?	☐ Yes	☐ No
18. Do you have tension headaches, tired muscles or sore teeth?	☐ Yes	☐ No
19. Do you wear, or have you ever worn, a bite appliance?	☐ Yes	☐ No
20. Have you ever had your bite adjusted?	☐ Yes	☐ No
TOOTH STRUCTURE		
21. Do you consider yourself cavity prone?	☐ Yes	☐ No
22. Do you have any sugar habits such as soda, juice, sports drinks, candy or gum?	☐ Yes	☐ No
23. Do you have dry mouth?	☐ Yes	☐ No
24. Are any teeth sensitive to hot, cold, biting pressure or sweets? *(please circle)*	☐ Yes	☐ No
25. Have you ever had a toothache, cracked filling, or a broken, chipped, or cracked tooth?	☐ Yes	☐ No
26. Do you avoid brushing any part of your mouth?	☐ Yes	☐ No
GUM & BONE		
27. Have you ever been diagnosed or treated for periodontal (gum) disease?	☐ Yes	☐ No
28. Have you ever experienced gum recession?	☐ Yes	☐ No
29. Is there anyone with a history of periodontal disease in your family?	☐ Yes	☐ No
30. Do your gums bleed when brushing, flossing or eating?	☐ Yes	☐ No
31. Are your teeth becoming loose?	☐ Yes	☐ No
32. Do you use: ☐ Manual Toothbrush ☐ Electronic toothbrush ☐ Waterfloss/Waterpik ☐ Floss		
33. Have you ever noticed an unpleasant taste or odor in your mouth?	☐ Yes	☐ No
34. On a scale of 1-10, how important is it for you to keep your teeth? *(ten being very important)* _____		

RESPONSIBLE PARTY/ INSURANCE SUBSCRIBER

Name: ____ Birth date:____/____/____
Address: ____
Sex: ___M ___F Social Security Number: ________________________ Contact Number: ______________________________
Relationship to patient: ________________________________ Employer: ______________________________

Please list additional family members:
Name: ________________________________ Birth date: ____/____/____
Name: ________________________________ Birth date: ____/____/____
Name: ________________________________ Birth date: ____/____/____
Name: ________________________________ Birth date: ____/____/____

Emergency Contact:
Name: ________________________________
Phone number: ________________________________
Relationship to patient: ________________________________

Please initial:

______ I consent to dental/ surgical procedures “agreed upon”. I will assume responsibility for fees associated with these procedures. To the best of my knowledge, all the information I have provided is correct. I commit to informing you of any changes to my health at my next appointment.

______ I give permission to use my photographs for educational purposes.

Patient Signature: ____ Date: ____/____/____