WELCOME TO OUR OFFICE

DATE:_____

NAME_____ SEX_____ MARITAL STATUS_____

BIRTHDATE_____ AGE_____ YOUR SOC. SEC. #_____*NOT SECURE TO SEND* EMAIL_____

HOME ADDRESS_____ CITY_____STATE_____ ZIP_____

HOME PHONE_____ CELL PHONE (if different)_____

NAME OF PERSON RESPONSIBLE FOR ACCOUNT_____ PHONE_____

YOUR EMPLOYER_____BUSINESS PHONE_____

SPOUSE'S NAME_____ BIRTHDATE:_____SPOUSE'S SOC. SEC. # _____

SPOUSE'S EMPLOYER_____ BUSINESS PHONE_____

PRIMARY DENTAL INSUR. CO. _____ POLICY/GROUP # _____ID#_____

SUBSCRIBER _____ BIRTHDATE _____

BILLING ADDRESS _____ CITY _____ STATE _____ ZIP _____

SECONDARY DENTAL INSUR. CO. _____ POLICY/GROUP # _____ID#_____

SUBSCRIBER _____ BIRTHDATE _____

BILLING ADDRESS _____ CITY _____ STATE _____ ZIP _____

MEDICAL HISTORY

	QUESTIONS	YES	NO	FOR DOCTOR'S USE
1	Have you been treated by a physician in the last five years?_____ For what reason?_____	☐	☐	
2	Have you gained or lost more than 10 pounds in the last three months?___	☐	☐	
	Do you take any medications/herbs (prescribed or over-the-counter)?_____	☐	☐	

Drug Dose Purpose

_____

_____

_____

_____

_____

_____

Are you allergic to any medications or substances (such as latex, metals, iodine, etc.)? Please list:	☐	☐

_____

_____

_____

_____

Please list hospitalizations and/or surgeries.

Date Procedure

_____

_____

_____

_____

	DO YOU HAVE OR HAVE YOU EVER HAD:	YES	NO	FOR DOCTOR'S USE
3	Heart disease, cardiac stent(s) or coronary artery bypass graft(s)?	☐	☐	
4	A history of infective endocarditis, rheumatic fever or scarlet fever?	☐	☐	
5	Artificial heart valve or a surgically repaired heart defect?	☐	☐	
6	A pacemaker or an implanted defibrillator?	☐	☐	
7	A heart murmur or mitral valve prolapse?	☐	☐	
8	Do you have high or low blood pressure?	☐	☐	
9	A stroke (taking blood thinners)?	☐	☐	
10	Consistently swollen ankles?	☐	☐	
11	Shortness of breath, even without exertion?	☐	☐	
12	Tire easily even with routine activities?	☐	☐	
13	A severe or prolonged cough?	☐	☐	
14	Asthma, emphysema, bronchitis, sarcoidosis or pleurisy?	☐	☐	
15	Tuberculosis?	☐	☐	
16	A blood disorder such as anemia or leukemia?	☐	☐	
17	A known bleeding disorder (Hemophilia, von Willebrand's, etc.)?	☐	☐	
18	Prolonged bleeding following a small cut or a tooth extraction?	☐	☐	
19	Easy bruising?	☐	☐	
20	Kidney disease, infections or dialysis?	☐	☐	
21	Liver disease (Hepatitis [type_____], cirrhosis, jaundice)?	☐	☐	
22	High cholesterol or taking statin drugs?	☐	☐	
23	Stomach problems including ulcers, hyperacidity or reflux?	☐	☐	
24	Intestinal or bowel problems?	☐	☐	
25	Diabetes? HbA1c=_____	☐	☐	
26	Thirsty frequently or urinate frequently?	☐	☐	
27	Thyroid, parathyroid or calcium deficiency?	☐	☐	
28	Hormone deficiency?	☐	☐	
29	Epilepsy, seizures or convulsions?	☐	☐	
30	Glaucoma?	☐	☐	
31	Neurologic problems?	☐	☐	
32	Frequent headaches?	☐	☐	
33	A severe head or neck injury? If so, when?	☐	☐	
34	Arthritis?	☐	☐	
45	An artificial joint or prothesis?	☐	☐	
46	Osteoporosis/Osteopenia?	☐	☐	
37	Taken bisphosphonate meds: Fosamax, Actonel, Boniva, Aredia, Zometa?	☐	☐	
38	Cancer, chemotherapy or radiation therapy?	☐	☐	
39	A blood transfusion?	☐	☐	
40	Viral infections or cold sores?	☐	☐	
41	Venereal disease?	☐	☐	
42	HIV/AIDS?	☐	☐	
43	Psychiatric treatment?	☐	☐	
44	Emotional problems, consider yourself a "touchy" person?	☐	☐	
45	Antidepressant medication?	☐	☐	
46	A medication for weight management (ie. fen-phen)?	☐	☐	
47	A habit of smoking or using smokeless tobacco (snuff)?	☐	☐	
	I have smoked_____packs per day for _____years. Quit in _____			
	I have chewed_____hours per day for _____years. Quit in _____			
48	Consumed alcohol on a regular basis?	☐	☐	
49	Any I.V., recreational, controlled or "street"drugs, including marijuana?	☐	☐	
	_____			
50	Are you being treated for sleep apnea with a CPAP or other appliance?	☐	☐	
51	Any disease, condition or problem not listed above?	☐	☐	
52	FEMALE- Taking birth control pills?	☐	☐	
53	FEMALE- Are you pregnant or suspect you may be? Due:_____	☐	☐	

DENTAL HISTORY

How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Previous dentist _____ How long have you been a patient? _____
Date of most recent dental exam _____/_____/_____ Date of most recent x-rays _____/_____/_____
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

	QUESTIONS	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 that one bite or do you clench (squeeze) to make your teeth fit together?_____	☐	☐
17	Do you have tension headaches or sore teeth?_____	☐	☐
18	Do you have any problems with sleep or wake up with an awareness of your teeth?_____	☐	☐
19	Do you clench or grind your teeth when asleep or awake?_____	☐	☐
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	Do you have a dry mouth?_____	☐	☐
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 do you avoid brushing any part of your mouth?_____	☐	☐
25	Do you have any 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 regularly get food caught between any of your teeth?_____	☐	☐
	GUM AND BONE		
28	Have you ever been diagnosed with or treated for periodontal (gum) disease?_____	☐	☐
29	Is there anyone with a history of periodontal disease in your family?_____	☐	☐
30	Have you ever experienced gum recession?_____	☐	☐
31	Do your gums bleed when you brush, floss, or eat?_____	☐	☐
32	Are your teeth becoming loose?_____	☐	☐
33	Have you ever noticed an unpleasant taste or odor in your mouth?_____	☐	☐
34	Have you experienced a burning sensation in your mouth?_____	☐	☐

35 How often do you brush your teeth? _____

36 How often do you floss your teeth? _____

37 Are there areas where flossing is difficult or impossible? Specify _____
_____

38 Besides tooth brush and floss, do you utilize other cleaning devices? Specify _____
_____

39 Please rank the following in their order of importance to YOU.
_____ FUNCTION - the ability to chew and speak properly.
_____ COMFORT - before, during and after treatment.
_____ COSMETICS - appearance of your mouth and teeth.
_____ ECONOMY - cost of, or value of treatment.
_____ HEALTH - control of dental disease.

40 Please rank in their order of importance to YOU those conditions that would prevent you from completing necessary dental treatment.
_____ Fear of pain or discomfort during treatment.
_____ Lack of concern for your well being by the doctor or staff.
_____ Cost of necessary dental treatment.
_____ Missing work several times for required appointments.

Primary Care Physician_____
Address_____ Phone_____

Specialty Physician_____ Specialty_____
Address_____ Phone_____

Specialty Physician_____ Specialty_____
Address_____ Phone_____

Who referred you to our office?_____

Patient's Signature_____ Date_____

Provider's Signature_____ Date_____