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?:

Do you have or have you ever had:

1. Most recent physical examination:
2. An allergic reaction to:
3. Heart problems, or cardiac stent within the last six months : No
4. History of infective endocarditis : No
5. Artificial heart valve, repaired heart defect (PFO) : No
6. Pacemaker or implantable defibrillator : No
7. Orthopedic implant (joint replacement) : No
8. Rheumatic or scarlet fever : No
9. High or low blood pressure : No
10. A stroke (taking blood thinners) : No
11. Anemia or other blood disorder : No
12. Emphysema, shortness of breath, sarcoidosis : No
13. Tuberculosis, measles, chicken pox : No
14. Asthma : No
15. Breathing or sleep problems (i.e.sleep apnea, snoring, sinus) : No
16. Kidney disease : No
17. Liver disease : No
18. Jaundice : No
19. Hormone deficiency : No
20. Diabetes (HbA1c=) : No
21. Stomach or duodenal ulcer : No
22. Digestive disorders (i.e.celiac disease, gastric reflux) : No
23. Osteoporosis/osteopenia (i.e.taking bisphosphonates) : No
24. Arthritis : No
25. Autoimmune disease : No
26. Glaucoma : No
27. Contact lenses : No
28. Head or neck injuries : No
29. Neurologic disorders (ADD/ADHD, prion disease) : No
30. Viral infections and cold sores : No
31. STI/STD/GPV : No
32. Hepatitis (type) : No
33. HIV/AIDS : No
34. Tumor, abnormal growth : No
35. Radiation therapy : No
36. Medication : No
37. Emotional difficulties : No
38. Psychiatric treatment : No
39. Antidepressant medication : No
40. Alcohol / recreational drug use : No

Are You:

41. Presently being treated for any other illness : No

42. Aware of a change in your health in the last 24 hours : No

43. Taking medication for weight management : No

44. Taking dietary supplements : No

45. Often exhausted or fatigued : No

46. Experiencing frequent headaches : No

47. A smoker, smoked previously or use smokeless tobacco : No

48. Considered a touchy / sensitive person : No

49. Often unhappy or depressed : No

50. FEMALE - taking birth control pills : No

51. FEMALE - pregnant : No

52. MALE - prostate disorders : No

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)

DENTAL HISTORY

Contact Information

Name:

Nickname: Age:

Referred by:

How would you rate the condition of your mouth?:

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:

WHAT IS YOUR IMMEDIATE CONCERN?:

Personal History

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) No

2. Have you had an unfavorable dental experience? No

3. Have you ever had complications from past dental treatment? No

4. Have you ever had trouble getting numb or had any reactions to local anesthetic? No

5. Did you ever have braces, orthodontic treatment or had your bite adjusted? No

6. Have you had any teeth removed? No

Gum and Bone

7. Do your gums bleed or are they painful when brushing or flossing? No

8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? No

9. Have you ever noticed an unpleasant taste or odor in your mouth? No

10. Is there anyone with a history of periodontal disease in your family? No

11. Have you ever experienced gum recession? No

12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? No

13. Have you experienced a burning sensation in your moth? No

Tooth Structure

14. Have you had any cavities within the past 3 years? No

15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? No

16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface or your teeth? No

17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? No

18. Do you have grooves or notches on your teeth near the gum line? No

19. Have you ever broken No

20. Do you frequently get food caught between any teeth? No

Bite and Jaw Joint

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) No

22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? No

23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? No

24. Have your teeth changed in the last 5 years, become shorter, thinner or worm? No

25. Are your teeth becoming more crooked, crowded, or overlapped? No

26. Are your teeth developing spaces or becoming more loose? No

27. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together? No

28. Do you place your tongue between your teeth or rest your teeth against your tongue? No

29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? No

30. Do you clench your teeth in the daytime or make them sore? No

31. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth? No

32. Do you wear or have you ever worn a bite appliance? No

Smile Characteristics

33. Is there anything about the appearance of your teeth that you would like to change? No

34. Have you ever whitened (bleached) your teeth? No

35. Have you felt uncomfortable or self conscious about the appearance of your teeth? No

36. Have you been disappointed with the appearance of previous dental work? No

Patient s Signature: Date:

Doctor s Signature: Date:

Confidential Information Questionnaire

Patients legal name:

Date of Birth: Sex:

Home Phone#:
Cell Phone#:
E-mail:

Prefer to call Social Security#:
Patients Address:

Marital Status:

Work Address

Spouses Name

Spouses Work Address

Emergency Contact Information

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

Request for Confidential Communication

AS MY DENTAL CARE PROVIDER, YOU MAY DO THE FOLLOWING WITH MY PERMISSION:

Contact me at home:

Contact me via cell phone:

Contact me at work:

Contact me via e-mail:

Leave message on my home voicemail / answering machine:

Leave messages on my cell phone voicemail:

Leave message on my work voicemail / answering machine:

Insurance and Financial Information

Insurance Coverage:

Subscribers Name	Patients Relationship to Subscriber	Subscribers Birthday	Subscribers ssn / id #

Secondary Coverage:

Subscribers Name	Patients Relationship to Subscriber	Subscribers Birthday	Subscribers ssn / id#

Release Information

YOU MAY DISCUSS MY HEALTHCARE WITH

Health care providers: Others (please print) Insurance Companies:

Confirmations

Do you prefer a confirmation call

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 making of videotapes, photographs, and x-rays before, during, and after treatment, and to use the same by the doctor in scientific papers or demonstrations. I certify that I have read or had to me the contents of this form and do realize the risks and limitations involved.

Patient s Signature:
Date:

Doctor s Signature:
Date: