

DENTAL HISTORY

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? _____ 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:

PERSONAL HISTORY

- | | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
|---|------------------------------|-----------------------------|
| 1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [] _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you had an unfavorable dental experience? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had complications from past dental treatment? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

GUM AND BONE

- | | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
|---|------------------------------|-----------------------------|
| 7. Do your gums bleed sometimes or are they ever painful when brushing or flossing? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever been treated for gum disease, had scaling and root planing, or been told you have lost bone around your teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever noticed an unpleasant taste or odor in your mouth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Is there anyone with a history of periodontal disease in your family? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever experienced gum recession, or can you see more of the roots of your teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

TOOTH STRUCTURE

- | | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
|--|------------------------------|-----------------------------|
| 14. Have you had any cavities within the past 3 years? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Do you have grooves or notches on your teeth near the gum line? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Do you frequently get food caught between any teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

BITE AND JAW JOINT

- | | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
|--|------------------------------|-----------------------------|
| 21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Are your teeth becoming more crooked, crowded, or overlapped? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Are your teeth developing spaces or becoming more loose? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Do you place your tongue between your teeth or close your teeth against your tongue? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Do you clench or grind your teeth together in the daytime or make them sore? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Do you wear or have you ever worn a bite appliance? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

SMILE CHARACTERISTICS

- | | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
|--|------------------------------|-----------------------------|
| 33. Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (shape, color, size, display)? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Have you ever bleached (whitened) your teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 36. Have you been disappointed with the appearance of previous dental work? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

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

YES NO

1. hospitalization for illness or injury _____
2. an allergic or bad reaction to any of the following:
 - aspirin, ibuprofen, acetaminophen, codeine _____
 - penicillin _____
 - erythromycin _____
 - tetracycline _____
 - sulfa _____
 - local anesthetic _____
 - fluoride _____
 - chlorhexidine (CHX) _____
 - iodine _____
 - metals (nickel, gold, silver, _____)
 - latex _____
 - nuts _____
 - fruit _____
 - milk _____
 - red dye _____
 - 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 or soft tissue implant (e.g. joint replacement, breast implant) _____
8. heart murmur, 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 (or INR > 3.5) _____
13. pneumonia, emphysema, shortness of breath, sarcoidosis _____
14. chronic ear infections, tuberculosis, measles, chicken pox _____
15. breathing problems (e.g. asthma, stuffy nose, sinus congestion) _____
16. sleep problems (e.g. sleep apnea, snoring, insomnia, restless sleep, bedwetting) _____
17. kidney disease _____
18. liver disease or jaundice _____
19. vertigo (e.g. "the room is spinning") _____
20. thyroid, parathyroid disease, or calcium deficiency _____
21. hormone deficiency or imbalance (e.g. polycystic ovarian syndrome) _____
22. high cholesterol or taking statin drugs _____
23. diabetes (HbA1c = _____) _____
24. stomach or duodenal ulcer _____
25. digestive or eating disorders (e.g. celiac disease, gastric reflux, bulimia, anorexia) _____

26. osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g. bisphosphonates) _____
27. arthritis or gout _____
28. autoimmune disease (e.g. rheumatoid arthritis, lupus, scleroderma) _____
29. glaucoma _____
30. contact lenses _____
31. head or neck injuries _____
32. epilepsy, convulsions (seizures) _____
33. neurologic disorders (e.g. Alzheimer's disease, dementia, 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 or antidepressant medication _____
45. concentration problems or ADD/ADHD _____
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 (e.g., fever, chills, new cough, or diarrhea) _____
49. taking medication for weight management _____
50. taking dietary supplements, vitamins, and/or probiotics _____
51. often exhausted or fatigued _____
52. experiencing frequent headaches or chronic pain _____
53. a smoker, smoked previously or other (e.g. smokeless tobacco, vaping, e-cigarettes, and cannabis) _____
54. considered a touchy/sensitive person _____
55. often unhappy or depressed _____
56. taking birth control pills _____
57. currently pregnant _____
58. diagnosed with a prostate disorder _____

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, vitamins, and/or probiotics 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 _____



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PATIENT INFORMATION:

Today's date: _____

Name (first/last): _____ Preferred Name: _____

If minor, Guarantor's Name: _____ & Date of Birth: _____

Male _____ Female _____ Single _____ Married _____ Divorced _____ Widowed _____ Minor _____

Date of Birth: ____/____/____ Social Security #: _____

Home address: _____ City: _____ State: _____ Zip: _____

Email address: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Place of Employment: _____

Who referred you to our office? _____

Major complaint or reason for today's visit: _____

Have you been seen for this condition? Y or N Date: _____ What was done? _____

In case of emergency, please notify:

Name: _____ Relationship: _____ Phone: _____

In consideration of the services rendered to me by this office, I am obligated to pay said office in accordance with its credit terms and policy. All today's procedures are expected to be paid in full: credit card, check, cash, payment plans available via Care Credit.

DENTAL INSURANCE INFORMATION

To be completed if you have Dental Insurance – Medicare and Health insurance do not pay for our services.

Please give your Dental Insurance card to the front desk person.

We will NOT be able to file dental insurance for you UNLESS we have a copy of the insurance card.

We do not accept assignment of insurance benefits; payment in full is due on the day of the appointment.

Primary Dental Insurance

Name of person that carries coverage: _____ D.O.B. _____

Dental Insurance Company: _____ Social Security/ID #: _____

All insurance re-imburements will be paid directly to you.

Assignment & Release: I authorize the dentist to release any information required for this claim.

Patient or Guarantor's signature: _____