# DENTAL HISTORY

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:** | **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 than one bite and squeeze to make your teeth fit together? _____ | ☐ | ☐ |
| 17. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ | ☐ | ☐ |
| 18. Do you clench your teeth in the daytime or make them sore? _____ | ☐ | ☐ |
| 19. Do you have any problems with sleep or wake up with an awareness of your teeth? _____ | ☐ | ☐ |
| 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. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ | ☐ | ☐ |
| 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 avoid brushing any part of your mouth? _____ | ☐ | ☐ |
| 25. Do you have 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 frequently get food caught between any teeth? _____ | ☐ | ☐ |
| **GUM AND BONE** | | |
| 28. Do your gums bleed or are they painful when brushing or flossing? _____ | ☐ | ☐ |
| 29. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ | ☐ | ☐ |
| 30. Have you ever noticed an unpleasant taste or odor in your mouth? _____ | ☐ | ☐ |
| 31. Is there anyone with a history of periodontal disease in your family? _____ | ☐ | ☐ |
| 32. Have you ever experienced gum recession? _____ | ☐ | ☐ |
| 33. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ | ☐ | ☐ |
| 34. Have you experienced a burning sensation in your mouth? _____ | ☐ | ☐ |

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 |
|---|---|---|
| 1. hospitalization for illness or injury_____ | ☐ | ☐ |
| 2. an allergic reaction to | | |
| ☐ aspirin, ibuprofen, acetaminophen, codeine | | |
| ☐ penicillin | | |
| ☐ erythromycin | | |
| ☐ tetracycline | | |
| ☐ sulfa | | |
| ☐ local anesthetic | | |
| ☐ fluoride | | |
| ☐ metals (nickel, gold, silver, _____) | | |
| ☐ latex | | |
| ☐ 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. artificial prosthesis (heart valve or joints) _____ | ☐ | ☐ |
| 8. 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 (INR > 3.5) _____ | ☐ | ☐ |
| 13. emphysema, sarcoidosis _____ | ☐ | ☐ |
| 14. tuberculosis _____ | ☐ | ☐ |
| 15. asthma _____ | ☐ | ☐ |
| 16. breathing or sleep problems (i.e. snoring, sinus)_____ | ☐ | ☐ |
| 17. kidney disease _____ | ☐ | ☐ |
| 18. liver disease _____ | ☐ | ☐ |
| 19. jaundice _____ | ☐ | ☐ |
| 20. thyroid, parathyroid disease, or calcium deficiency _____ | ☐ | ☐ |
| 21. hormone deficiency _____ | ☐ | ☐ |
| 22. high cholesterol or taking statin drugs _____ | ☐ | ☐ |
| 23. diabetes (HbA1c = _____) _____ | ☐ | ☐ |
| 24. stomach or duodenal ulcer _____ | ☐ | ☐ |
| 25. digestive disorders (i.e. gastric reflux)_____ | ☐ | ☐ |

| | YES | NO |
|---|---|---|
| 26. osteoporosis/osteopenia (i.e. taking bisphosphonates) __ | ☐ | ☐ |
| 27. arthritis _____ | ☐ | ☐ |
| 28. glaucoma_____ | ☐ | ☐ |
| 29. contact lenses _____ | ☐ | ☐ |
| 30. head or neck injuries _____ | ☐ | ☐ |
| 31. epilepsy, convulsions (seizures) _____ | ☐ | ☐ |
| 32. neurologic problems (attention deficit disorder) _____ | ☐ | ☐ |
| 33. viral infections and cold sores _____ | ☐ | ☐ |
| 34. any lumps or swelling in the mouth_____ | ☐ | ☐ |
| 35. hives, skin rash, hay fever_____ | ☐ | ☐ |
| 36. STI / STD _____ | ☐ | ☐ |
| 37. hepatitis (type ___) _____ | ☐ | ☐ |
| 38. HIV / AIDS _____ | ☐ | ☐ |
| 39. tumor, abnormal growth_____ | ☐ | ☐ |
| 40. radiation therapy_____ | ☐ | ☐ |
| 41. chemotherapy_____ | ☐ | ☐ |
| 42. emotional problems _____ | ☐ | ☐ |
| 43. psychiatric treatment_____ | ☐ | ☐ |
| 44. antidepressant medication _____ | ☐ | ☐ |
| 45. alcohol / street drug use _____ | ☐ | ☐ |
| **ARE YOU:** | | |
| 46. presently being treated for any other illness _____ | ☐ | ☐ |
| 47. aware of a change in your health (i.e. fever, new cough)__ | ☐ | ☐ |
| 48. taking medication for weight management (i.e. fen-phen) | ☐ | ☐ |
| 49. taking dietary supplements_____ | ☐ | ☐ |
| 50. often exhausted or fatigued _____ | ☐ | ☐ |
| 51. experiencing frequent headaches_____ | ☐ | ☐ |
| 52. a smoker, smoked previously or use smokeless tobacco _ | ☐ | ☐ |
| 53. considered a touchy person _____ | ☐ | ☐ |
| 54. often unhappy or depressed_____ | ☐ | ☐ |
| 55. FEMALE - taking birth control pills _____ | ☐ | ☐ |
| 56. FEMALE - pregnant _____ | ☐ | ☐ |
| 57. MALE - prostate disorders _____ | ☐ | ☐ |

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 |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Ask for an additional sheet if you are taking more than 6 medications

**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 _____

PLEASE PRINT

# CONFIDENTIAL INFORMATION QUESTIONNAIRE

| PATIENT'S LEGAL NAME LAST, FIRST MI | DATE OF BIRTH | SEX | SOCIAL SECURITY # |
|---|---|---|---|
| | | | |

| PREFER TO BE CALLED | HOME PHONE # | CELL PHONE # |
|---|---|---|
| | | |

| PATIENT'S ADDRESS STREET APT# CITY STATE ZIP | E-MAIL |
|---|---|
| | |

| MARITAL STATUS<br>☐ S ☐ M ☐ W ☐ D<br>☐ UNDER AGE 18 | PATIENT'S / GUARDIAN'S EMPLOYER | OCCUPATION |
|---|---|---|
| | | |

| WORK ADDRESS STREET APT# CITY STATE ZIP | WORK PHONE # |
|---|---|
| | |

| SPOUSE'S NAME LAST, FIRST MI | SPOUSE'S EMPLOYER | OCCUPATION |
|---|---|---|
| | | |

| SPOUSE'S WORK ADDRESS STREET APT# CITY STATE ZIP | WORK PHONE # |
|---|---|
| | |

| OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE | WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE? |
|---|---|
| | |

# EMERGENCY CONTACT INFORMATION

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

| NAME | RELATIONSHIP |
|---|---|
| | |

| HOME PHONE # | WORK PHONE # | CELL PHONE # |
|---|---|---|
| | | |

# REQUEST FOR CONFIDENTIAL COMMUNICATION

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

| | YES | NO |
|---|---|---|
| Contact me at home | ☐ | ☐ |
| Contact me via cell phone | ☐ | ☐ |
| Contact me at work | ☐ | ☐ |
| Contact me via e-mail | ☐ | ☐ |
| Leave messages on my home voicemail / answering machine | ☐ | ☐ |
| Leave messages on my cell phone voicemail | ☐ | ☐ |
| Leave messages on my work voicemail / answering machine | ☐ | ☐ |

PLEASE PRINT

# INSURANCE AND FINANCIAL INFORMATION

| INSURANCE COVERAGE ☐ YES ☐ NO | INSURANCE COMPANY NAME | INSURANCE ADDRESS | INSURANCE PHONE |
|---|---|---|---|
| SUBSCRIBER'S NAME | PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ DEPENDENT | SUBSCRIBER'S BIRTHDAY | SUBSCRIBER'S SSN / ID # |
| GROUP / PROGRAM NUMBER | EMPLOYER (IF DIFFERENT FROM ABOVE) | EMPLOYER'S ADDRESS | |

| SECONDARY COVERAGE ☐ YES ☐ NO | INSURANCE COMPANY NAME | INSURANCE ADDRESS | INSURANCE PHONE |
|---|---|---|---|
| SUBSCRIBER'S NAME | PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ DEPENDENT | SUBSCRIBER'S BIRTHDAY | SUBSCRIBER'S SSN / ID # |
| GROUP / PROGRAM NUMBER | EMPLOYER (IF DIFFERENT FROM ABOVE) | EMPLOYER'S ADDRESS | |

# RELEASE INFORMATION

## YOU MAY DISCUSS MY HEALTHCARE WITH

| | YES | NO |
|---|---|---|
| Health Care Providers | ☐ | ☐ |
| Insurance Companies | ☐ | ☐ |

**OTHERS (PLEASE PRINT)**

1.

2.

# CONFIRMATIONS

## DO YOU PREFER A CONFIRMATION CALL

☐ No, it is unnecessary ☐ Yes, it is a helpful reminder

# 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 read to me the contents of this form and do realize the risks and limitations involved.

| SIGNATURE - PATIENT / GUARDIAN | DATE |
|---|---|
| WITNESS SIGNATURE | DATE |