

Welcome

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient Information (CONFIDENTIAL)

Patient # _____
SS#/SIN _____
Date _____
Name _____ Birthdate _____ Home Phone _____
Address _____ City _____ State/Prov. _____ Zip/P.C. _____
Email _____ Cell Phone _____
Check Appropriate Box: Minor Single Married Divorced Widowed Separated
If Student, Name of School/College _____ City _____ State/Prov. _____ Full Time Part Time
Patient or Parent/Guardian's Employer _____ Work Phone _____
Business Address _____ City _____ State/Prov. _____ Zip/P.C. _____
Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____
Whom may we thank for referring you? _____
Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____
Address _____ Home Phone _____
Email _____ Cell Phone _____
Driver's License# _____ Birthdate _____ Financial Institution _____
Employer _____ Work Phone _____ SS#/SIN _____

Is this person currently a patient in our office? Yes No
For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.
 Cash Personal Check Credit Card VISA MasterCard I wish to discuss the office's payment policy.
 Discover AMEX

Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/SIN _____ Date Employed _____
Name of Employer _____ Union or Local# _____ Work Phone _____
Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____
Insurance Company _____ Group# _____ Policy/ID# _____
Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/SIN _____ Date Employed _____
Name of Employer _____ Union or Local# _____ Work Phone _____
Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____
Insurance Company _____ Group# _____ Policy/ID# _____
Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

Over Please

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

YES NO

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

GUM AND BONE

YES NO

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

TOOTH STRUCTURE

YES NO

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

BITE AND JAW JOINT

YES NO

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

SMILE CHARACTERISTICS

YES 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)? _____ YES NO
34. Have you ever bleached (whitened) your teeth? _____ YES NO
35. Have you felt uncomfortable or self-conscious about the appearance of your teeth? _____ YES NO
36. Have you been disappointed with the appearance of previous dental work? _____ YES NO

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. poly cystic 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 _____