

# PATIENT INFORMATION

ALL INFORMATION WILL BE HELD IN STRICT CONFIDENCE.

Name: Mr/Mrs/Ms \_\_\_\_\_ Date \_\_\_\_\_

Social Security Number \_\_\_\_\_ Birth Date \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work \_\_\_\_\_

E-mail \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Referred to us by \_\_\_\_\_

Reason for leaving your last dentist \_\_\_\_\_

Your Primary Physician's Name \_\_\_\_\_

Date of Last Visit \_\_\_\_\_ Purpose \_\_\_\_\_

Findings \_\_\_\_\_

## DENTAL HISTORY

Good oral health is part of your overall health and well-being. These questions will help us assess your overall oral health and give us important information before we start your exam.

What is your estimate of your dental health?.....  GOOD  FAIR  POOR

How often do you brush and/or floss your teeth?..... \_\_\_\_\_

Are you currently in pain? (If yes, explain below).....  YES  NO

Are you apprehensive about dental treatment?.....  YES  NO

Do you use tobacco products? ( Cigarettes  Pipe  Cigar  Chew).....  YES  NO  IN PAST

Do your gums bleed during brushing or flossing?.....  YES  NO

Do you require antibiotics before dental treatment?.....  YES  NO

Have you been treated for periodontal disease?.....  YES  NO

Are your teeth sensitive to heat, cold or anything else?.....  YES  NO

Please fully explain any "Yes" answers: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

# MEDICAL HISTORY

Have you been under the care of a physician recently?..... YES  NO

Currently or recently, have you taken any drugs, pills or medications? ..... YES  NO

If "Yes", please list: \_\_\_\_\_

Do you have any allergies to drugs or medications?..... YES  NO

If "Yes", please list: \_\_\_\_\_

**Please indicate if you currently have or ever had any of the following:**

- |   |  |
|---|--|
| High blood pressure ..... <input type="checkbox"/> YES <input type="checkbox"/> NO          | Asthma ..... <input type="checkbox"/> YES <input type="checkbox"/> NO                  |
| Low blood pressure ..... <input type="checkbox"/> YES <input type="checkbox"/> NO           | Shortness of breath ..... <input type="checkbox"/> YES <input type="checkbox"/> NO     |
| Heart murmur ..... <input type="checkbox"/> YES <input type="checkbox"/> NO                 | Dizzy spells/seizure ..... <input type="checkbox"/> YES <input type="checkbox"/> NO    |
| Chest Pain ..... <input type="checkbox"/> YES <input type="checkbox"/> NO                   | Antibiotic allergy ..... <input type="checkbox"/> YES <input type="checkbox"/> NO      |
| Mitral valve prolapse ..... <input type="checkbox"/> YES <input type="checkbox"/> NO        | Latex allergy ..... <input type="checkbox"/> YES <input type="checkbox"/> NO           |
| Hepatitis ..... <input type="checkbox"/> YES <input type="checkbox"/> NO                    | Diabetes ..... <input type="checkbox"/> YES <input type="checkbox"/> NO                |
| HIV/AIDS ..... <input type="checkbox"/> YES <input type="checkbox"/> NO                     | Artificial joint ..... <input type="checkbox"/> YES <input type="checkbox"/> NO        |
| Arthritis ..... <input type="checkbox"/> YES <input type="checkbox"/> NO                    | Kidney or liver disease ..... <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Sleep apnea ..... <input type="checkbox"/> YES <input type="checkbox"/> NO                  | Rheumatic fever ..... <input type="checkbox"/> YES <input type="checkbox"/> NO         |
| Psychiatric treatment ..... <input type="checkbox"/> YES <input type="checkbox"/> NO        | Tuberculosis ..... <input type="checkbox"/> YES <input type="checkbox"/> NO            |
| Anemia/blood disorder ..... <input type="checkbox"/> YES <input type="checkbox"/> NO        | Radiation/chemo ..... <input type="checkbox"/> YES <input type="checkbox"/> NO         |
| Thyroid/parathyroid disorder ..... <input type="checkbox"/> YES <input type="checkbox"/> NO | Drug use or alcoholism ..... <input type="checkbox"/> YES <input type="checkbox"/> NO  |

**Are you:**

- Presently being treated for any illness?..... YES  NO  
Aware of any recent weight change? ..... YES  NO  
Aware of any recent change in health? ..... YES  NO  
Subject to frequent headaches? ..... YES  NO

**If female, are you:**

- Pregnant?..... YES  NO  
Nursing?..... YES  NO  
Taking birth control pills?..... YES  NO

Please list any serious medical condition(s) that you may have experienced.

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**PLEASE INFORM THE DOCTOR IF YOUR HEALTH CHANGES IN ANY WAY.**

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all the questions truthfully and to the best of my knowledge.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

# JAW/BITE ANALYSIS

*The alignment of your bite can affect your health in more ways than you may realize.  
We consider a proper bite to be a critical part of your overall health and appearance.*

**Do you experience any of the following?**

- |   |   |                                  |    |          |
|---|---|----------------------------------|----|----------|
| <input type="checkbox"/> Neck pain                          | <input type="checkbox"/> Ear congestion                         | L                                | R  |          |
| <input type="checkbox"/> Ear pain                           | <input type="checkbox"/> Tinnitus (ringing sound in ears)       | L                                | R  |          |
| <input type="checkbox"/> Shoulder pain                      | <input type="checkbox"/> Clicking or popping sound in jaw joint | L                                | R  |          |
| <input type="checkbox"/> Jaw joint pain                     | <input type="checkbox"/> Grating sound in jaw joint             | L                                | R  |          |
| <input type="checkbox"/> General facial pain                | <input type="checkbox"/> Inability to open mouth                | Constant                         | or | Sporadic |
| <input type="checkbox"/> Face muscle twitches               | <input type="checkbox"/> Dizziness                              |                                  |    |          |
| <input type="checkbox"/> Difficulty swallowing              | <input type="checkbox"/> Chipping or breaking teeth             |                                  |    |          |
| <input type="checkbox"/> Difficulty breathing through nose  | <input type="checkbox"/> Grind teeth in the daytime             |                                  |    |          |
| <input type="checkbox"/> Difficulty chewing                 | <input type="checkbox"/> Grind teeth during sleeping            |                                  |    |          |
| <input type="checkbox"/> Sensitivity to hot or cold         | <input type="checkbox"/> Loose teeth (specify) _____            |                                  |    |          |
| <input type="checkbox"/> Tightness/soreness in jaw muscles? | _____   |                                  |    |          |
| <input type="checkbox"/> Morning                            | <input type="checkbox"/> After meals                            | <input type="checkbox"/> Evening |    |          |

**Headaches:**  Migraines  Tension headaches  Other, explain: \_\_\_\_\_

How often do you experience headaches? \_\_\_\_\_

Where are they located?

- |              |   |   |
|--------------|---|---|
| Top of head  | L | R |
| Forehead     | L | R |
| Temples      | L | R |
| Behind eyes  | L | R |
| Back of head | L | R |

## HABITS

### Oral Habits

- Chew gum
- Bite on pencils/pens
- Bite nails
- Bite cheeks
- Smoke pipes
- Smoke cigarettes
- Other: \_\_\_\_\_

### Postural Habits

- Snoring
- Cradle the telephone with shoulder
- Lean chin on hand
- Carry a shoulderbag
- Other: \_\_\_\_\_

## SMILE ANALYSIS

Your smile says a lot about you. What do you say about it? Please describe your smile so we know what's important to you.

When I see a picture of myself, the first thing I notice about my smile is: \_\_\_\_\_

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Something I often notice about other smiles that I consider attractive is: \_\_\_\_\_

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*An attractive, healthy smile is important to everyone.*

On a scale of 1 to 10 (10 being the best), I would rate my smile as:

1 2 3 4 5 6 7 8 9 10

### PLEASE MARK THE STATEMENTS BELOW THAT YOU AGREE WITH.

- I have often wished I could change some of the features of my smile.
- I wish the color of my teeth were whiter.
- I wish I had a broader smile.
- I think some of my teeth are too small.
- I wish my teeth were straighter.
- I think my gums show too much when I smile.
- I think my smile shows too much space between some of my teeth.
- Because I am not totally pleased with my smile, I sometimes hesitate to smile.
- I feel as though I don't really know all of the options available for enhancing my smile.

EXPERIENCE TO ENHANCE YOUR SMILE,  
*and Your Life*

# EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently, try to work out how they would have affected you.

Use the following scale to choose the **most appropriate number** for each situation:

0 = would **never** doze

1 = **slight chance** of dozing

2 = **moderate chance** of dozing

3 = **high chance** of dozing

*It is important that you answer each question as best you can.*

Situation	Chance of Dozing (0-3)
Sitting and reading _____	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
Watching TV _____	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
Sitting, inactive in a public place (e.g. a theatre or a meeting) _____	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
As a passenger in a car for an hour without a break _____	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
Lying down to rest in the afternoon when circumstances permit _____	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
Sitting and talking to someone _____	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
Sitting quietly after a lunch without alcohol _____	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
In a car, while stopped for a few minutes in traffic _____	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
Total _____	<input type="text"/>

Score:

0-10 Normal range

10-12 Borderline

12-24 Abnormal