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: ____________________________

____

____

(over)

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

______

______

______

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?

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

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: ____

____

____

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

____

____

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.

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 ______	☐ 0 ☐ 1 ☐ 2 ☐ 3
Watching TV ______	☐ 0 ☐ 1 ☐ 2 ☐ 3
Sitting, inactive in a public place (e.g, a theatre or a meeting) ______	☐ 0 ☐ 1 ☐ 2 ☐ 3
As a passenger in a car for an hour without a break ______	☐ 0 ☐ 1 ☐ 2 ☐ 3
Lying down to rest in the afternoon when circumstances permit ______	☐ 0 ☐ 1 ☐ 2 ☐ 3
Sitting and talking to someone ______	☐ 0 ☐ 1 ☐ 2 ☐ 3
Sitting quietly after a lunch without alcohol ______	☐ 0 ☐ 1 ☐ 2 ☐ 3
In a car, while stopped for a few minutes in traffic ______	☐ 0 ☐ 1 ☐ 2 ☐ 3
Total ______	______

Score:

0-10	Normal range
10-12	Borderline
12-24	Abnormal