Patient Information

All information will be held in strict confidence.

Name: Mr/Mrs/Ms_____ Preferred Name_____

Social Security Number_____ Birth Date_____

Address_____

City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Work_____

E-mail_____

Employer_____ Occupation_____

Primary Insurance Company_____

Policy Holder Name_____ Birth Date_____ SSN_____

Secondary Insurance Company_____

Policy Holder Name_____ Birth Date_____ SSN_____

Emergency Contact_____ Phone Number_____

Referred to us by: ❑ TV ❑ Search Engine ❑ Social Media

❑ Friend (Name)_____ ❑ Other_____

Reason for leaving your last dentist_____

_____

_____

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

Are you currently in pain?..... ❑ YES ❑ NO

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

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

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

Have you ever had orthodontic treatment (braces)?..... ❑ YES ❑ NO

Do you experience dry mouth?..... ❑ YES ❑ NO

Please fully explain any "YES" answers:_____

_____

_____

Medical History

Name of Primary Care Provider_____

Are you currently being treated for any illness?..... ❑ YES ❑ NO

If "YES" please list_____

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:

Latex Allergy..... ❑ YES ❑ NO
Antibiotic Allergy..... ❑ YES ❑ NO
Acid Reflux..... ❑ YES ❑ NO
Anemia/Blood Disorder..... ❑ YES ❑ NO
Arthritis..... ❑ YES ❑ NO
Artificial Joint/Heart Valves..... ❑ YES ❑ NO
Asthma..... ❑ YES ❑ NO
Autoimmune Disease..... ❑ YES ❑ NO
Cancer..... ❑ YES ❑ NO
Cold Sores/Fever Blisters..... ❑ YES ❑ NO
Diabetes..... ❑ YES ❑ NO
Dizzy Spells/Vertigo..... ❑ YES ❑ NO
Drug Use/Alcoholism..... ❑ YES ❑ NO
Eating Disorder..... ❑ YES ❑ NO
Ever Taken Bisphosphonates (Fosamax, Boniva, etc.) ❑ YES ❑ NO
Heart Attack..... ❑ YES ❑ NO
Heart Disease..... ❑ YES ❑ NO
Hepatitis..... ❑ YES ❑ NO

High Blood Pressure..... ❑ YES ❑ NO
HIV/AIDS..... ❑ YES ❑ NO
Infective Endocarditis..... ❑ YES ❑ NO
Kidney/Liver Disease..... ❑ YES ❑ NO
Osteoporosis..... ❑ YES ❑ NO
Pacemaker..... ❑ YES ❑ NO
Psychiatric Treatment..... ❑ YES ❑ NO
Radiation/Chemotherapy..... ❑ YES ❑ NO
Respiratory Problems..... ❑ YES ❑ NO
Seizures..... ❑ YES ❑ NO
Sleep Apnea..... ❑ YES ❑ NO
Steroid Treatments..... ❑ YES ❑ NO
Stroke..... ❑ YES ❑ NO
Thyroid/Parathyroid Disorder..... ❑ YES ❑ NO
Tuberculosis..... ❑ YES ❑ NO
Pregnant..... ❑ YES ❑ NO
Nursing..... ❑ YES ❑ NO
Taking birth control pills..... ❑ YES ❑ NO

Please list any hospitalizations or 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
- ❑ Other:_____

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:_____

Epworth Sleepiness Scale

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

0 = Would never doze 1= Slight chance of dozing 2 = Moderate chance of dozing 3 = High chance of dozing

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

Total_____

Score: 0-10 Normal Range 10-12 Borderline 12-24 Abnormal Epworth Sleepiness Scale

Smile Analysis

Your smile says a lot about you and can influence how you interact with other people. Please describe your smile so we know what is important to you.

How do you feel about your smile?

❑ I love my smile ❑ It's OK ❑ I want a better smile

Please Explain:_____

_____

How do you feel when others see your smile?

❑ Confident ❑ Neutral ❑ Embarrassed

Please Explain:_____

_____

Are there any facial aesthetics that concern you?

❑ YES ❑ NO

Please Explain (forehead lines, crow's feet, lip appearance, etc.):_____

_____