



PATIENT NAME (Last) (First) (M.I.) BIRTHDATE PATIENT'S SS#

HOME ADDRESS STREET CITY ZIP HOME PHONE

PLACE OF EMPLOYMENT OCCUPATION BUSINESS PHONE

SINGLE MARRIED DIVORCED WIDOWED SEPARATED SPOUSE'S NAME SPOUSE'S BIRTHDATE

SPOUSE'S PLACE OF EMPLOYMENT SPOUSE'S WORK PHONE SPOUSE'S SS#

EMAIL: CELL PHONE:

Are you taking any medication now? YES NO

If so, what and why?

List Medications

Primary Dental Insurance

Insurance Co. Name:

Insurance Co. Address:

Insurance Co. Phone #:

Group # (Plan, Local or Policy #):

Insured's Name: Relation:

Insured's Birthdate: Insured's SS #:

Insured's Employer:

Person Responsible for Account: Who may we THANK for referring you?

MEDICAL HEALTH

GENERAL HEALTH (Please Check) EXCELLENT GOOD FAIR POOR

Name of physician and date of last complete physical:

Have you or your physician been concerned about the following?

- Anxiety/Nervousness YES NO Cancer YES NO
Heart disease YES NO Ulcers YES NO
Congenital heart lesions YES NO Asthma or hay fever YES NO
Heart murmur YES NO Sinus trouble YES NO
Hepatitis, Jaundice YES NO Radiation treatments/Chemotherapy YES NO
Artificial joints YES NO Abnormal blood pressure YES NO
Tuberculosis or lung disease YES NO Arthritis YES NO
Diabetes YES NO Stroke YES NO
Epilepsy YES NO Prolonged bleeding/Transfusion YES NO
Anemia YES NO Do you snore? YES NO
Unintentional weight loss YES NO History of Osteoporosis YES NO
HIV (AIDS) YES NO
Do you smoke? YES NO

And how much?

Are you allergic to: Penicillin Codeine Local injected anesthetics Other medications
Latex Metals

(WOMEN)

Are you taking oral contraceptives? YES NO

Are you pregnant? YES NO How far along?

Signature Date

# 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, and at what age? \_\_\_\_\_
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma? \_\_\_\_\_

## GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing? \_\_\_\_\_
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? \_\_\_\_\_
9. Have you ever noticed an unpleasant taste or odor in your mouth? \_\_\_\_\_
10. Is there anyone with a history of periodontal disease in your family? \_\_\_\_\_
11. Have you ever experienced gum recession? \_\_\_\_\_
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? \_\_\_\_\_
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? \_\_\_\_\_

## TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years? \_\_\_\_\_
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? \_\_\_\_\_
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? \_\_\_\_\_
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? \_\_\_\_\_
18. Do you have grooves or notches on your teeth near the gum line? \_\_\_\_\_
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? \_\_\_\_\_
20. Do you frequently get food caught between any teeth? \_\_\_\_\_

## BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) \_\_\_\_\_
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together? \_\_\_\_\_
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? \_\_\_\_\_
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? \_\_\_\_\_
25. Are your teeth becoming more crooked, crowded, or overlapped? \_\_\_\_\_
26. Are your teeth developing spaces or becoming more loose? \_\_\_\_\_
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? \_\_\_\_\_
28. Do you place your tongue between your teeth or close your teeth against your tongue? \_\_\_\_\_
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? \_\_\_\_\_
30. Do you clench or grind your teeth together in the daytime or make them sore? \_\_\_\_\_
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? \_\_\_\_\_
32. Do you wear or have you ever worn a bite appliance? \_\_\_\_\_

## SMILE CHARACTERISTICS

33. Is there anything about the appearance of your teeth that you would like to change (shape, color, size)? \_\_\_\_\_
34. Have you ever whitened (bleached) your teeth? \_\_\_\_\_
35. Have you felt uncomfortable or self-conscious about the appearance of your teeth? \_\_\_\_\_
36. Have you been disappointed with the appearance of previous dental work? \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_