

Health and Dental History

Name _____ Date _____

Have you been under the care of a medical doctor during the past 5 years? Yes No

If yes, list reason(s) _____

Name of M.D. _____ Phone _____

List current medications you take including aspirin and nutritional supplements _____

Have you had an adverse reaction to any medications in the past? Yes No

If Yes, list and describe _____

Allergies Yes No

List _____

Heart Disease/Surgery Yes No

Describe _____

High Blood Pressure Yes No

Stroke Yes No

Asthma/Breathing Problem Yes No

Emphysema/Lung Disease Yes No

Hepatitis/Liver Disease Yes No

Joint Replacement Yes No

If yes, when? _____

Kidney Disease Yes No

Cancer Yes No

If yes, describe _____

Epilepsy/Seizures Yes No

Diabetes Yes No

H.I.V. Yes No

Neurological Disorder Yes No

Psychiatric/Psychological issue Yes No

Fainting/Dizziness Yes No

Bleeding Problem Yes No

Glaucoma/Eye Problem Yes No

Have you taken Bisphosphonates, such as Fosamax,

Boniva or other? Yes No

Do you use tobacco? Yes No

How many alcohol drinks per week? _____

Do you use recreational drugs? Yes No

Insomnia/Frequent Waking Yes No

Ear Congestion Yes No

Ringling Ears/Tinitis Yes No

Headaches/Migraines Yes No

Difficulty Swallowing Yes No

Snoring/Sleep Apnea Yes No

Neck pain Yes No

Posture Problems Yes No

Do you see a chiropractor Yes No

Tingling Arms/Fingers Yes No

Facial Pain Yes No

Jaw Pain Yes No

Jaw Popping/Jaw Joint Noise Yes No

Limited Jaw Opening Yes No

Loose Teeth Yes No

Jaw Clenching/Teeth Grinding Yes No

Sensitive Teeth Yes No

Difficulty Chewing Yes No

Bite Problem Yes No

Trigeminal Neuralgia Yes No

Have you had orthodontics? Yes No

Crowded tongue Yes No

Does food pack between teeth? Yes No

Do your gums bleed? Yes No

Does your breath concern you? Yes No

Other problems not listed here? Yes No

If yes, describe _____

Women Only:

Are you pregnant? Yes No

Are you planning a pregnancy? Yes No

Are you nursing? Yes No

Are you taking birth control pills? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency who may release such information to you. I will notify the doctor of change in my health and medication.

Patient (Print Name)

(Patient Signature)

(Date)

For Your Comfort

Your comfort is our priority. We provide a variety of services to assure that you are comfortable at all times.

1. Patients find that if they take an analgesic prior to treatment, it helps later in the day. Which do you prefer?

Tylenol

Advil

Other (please specify) _____

2. We provide various levels of sedation. *The Wand* is today's most comfortable numbing technology and we use it routinely. Used in combination with an extremely effective topical medication, *The Wand* allows you to get numb feeling virtually nothing. Would you benefit from a sedative?

Yes

No (please explain) _____

If yes, please circle which method you prefer:

Nitrous Oxide

Mild Sedative pill

Moderate Sedative pill

I.V. Sedation (with our anesthesiologist)

4. Our rooms are equipped with video players and movie glasses. Watching movies and videos is an excellent way to pass the time during your visit. Would you like to watch a movie during your next visit?

Yes No

(Note: We have movies available on-site or please feel free to bring your own)

5. What type of movies do you like? What are your three favorite movies? _____

5. Is there anything else we can do to make your visit more comfortable? _____

How Can We Help You?

Name _____ Date _____

1. What is the reason for your visit? _____

2. What do you think is the current state of your mouth's health? _____

3. What are your treatment goals? (Check one):

Pain relief/repairs only

Average Care

The best it can be

Other (please specify) _____

4. Please tell us about your good dental experiences _____

5. Please tell us about your bad dental experiences _____

6. Why are you consulting with us rather than your previous dentist? _____

7. What about your smile would you like to improve (if anything)? _____

8. Do you have any friends or family that come to this office? Yes No

If yes, who? _____

9. What do you already know about our office and what are your expectations? _____

10. Has fear ever been an issue for you at the dentist? Yes No

If yes, please tell us more _____

11. Has time ever been an issue for you in getting your dental work done? Yes No
If yes, please explain _____

12. Is the cost of dental treatment a concern for you? Yes No.
If yes, would you like to discuss affordability options, such as financing? Yes No

13. We can look at your mouth from 3 different perspectives. Which of these would you like us to use for you? (Please check all that apply.)

- As a General Dentist
- As a Cosmetic Dentist
- As a Functional Dentist

14. At what point do you want us to initiate treatment? (Please check one.)

- When my tooth hurts/breaks
- When something is worsening
- When it's not ideal
- Other _____

15. What additional information would you like us to know? _____

16. How did you find out about our office? (Please check all that apply.)

- Personal Referral from _____
- Postcard
- Newspaper
- T.V. Commercial
- Internet
- Other

If you found us on the internet, what search words did you use? _____

Patient Information

Patient Name _____

Address _____

City _____ State _____ Zip _____

Cell Phone _____

Home Phone _____

Work Phone _____

Email _____

Occupation _____

Date of Birth _____ Age _____ Sex (circle one) F M

Marital Status (please circle one)

Single

Married

Divorced

Widowed

Social Security # _____

Dental Insurance Company _____

Subscriber's Name _____

Subscriber's Date of Birth _____

Subscriber's I.D. or SSN Group # _____

Relationship to Patient _____

Employer _____

Employer Telephone _____

Employer Address _____

Emergency Contact Information

Name _____ Telephone _____

Relationship to Patient _____