Patient Information

Name: _____ Date: _____

Gender: M or F Marital Status: _____ Date of Birth: _____ SS #: _____

Address: _____ City, State & Zip: _____

Phone Numbers: Home: _____ Cell: _____ Work: _____

Email Address: _____

Best way to confirm appointments? ☐ Home ☐ Email ☐ Cell ☐ Work

Employer: _____

Spouse's Name: _____ Spouse's Employer: _____

Emergency Contact & Phone Number: _____

Dental Insurance Information

Primary Insurance: _____

Patients Relationship to Insured (please circle): Self Spouse Child Other

Name of Subscriber: _____

Subscriber's Birthdate: _____ Social Security #: _____

Subscriber's Address: _____ Subscriber's Employer _____

Secondary Insurance: _____

Patients Relationship to Insured (please circle): Self Spouse Child Other

Name of Subscriber: _____

Subscriber's Birthdate: _____ Social Security #: _____

Subscriber's Address: _____ Subscriber's Employer _____

Medical & Dental History

Patient Name: _____ **Date of Birth: _____**

Name & Phone number of Medical Doctor: _____

Are you currently under a physician's care? ☐ Yes ☐ No Date of last medical visit: _____

Medications currently taking: _____

Have you ever had any of the following? Please check those that apply:

- ☐ Allergies
  If yes, to what:
  _____
- ☐ Metal reactions
- ☐ Heart disease
  If yes, what type?
  _____
- ☐ Stents
- ☐ Rheumatic fever
- ☐ Heart murmur
- ☐ Pacemaker
- ☐ Heart valve problems/MVP
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Hepatitis
- ☐ Aids/Immune disorders
- ☐ Tuberculosis
- ☐ Diabetes
- ☐ Seizures
- ☐ Epilepsy
- ☐ Anemia
- ☐ Venereal disease
- ☐ Cancer
  If yes, what type
  _____
- ☐ Joint replacement
  If yes, what type
  _____
  Who performed the surgery?
  Date?
  _____
- ☐ Prolonged bleeding
- ☐ Asthma
- ☐ Unusual reaction to anesthetic or drug
- ☐ Allergy to novacaine
- ☐ Allergy to latex
- ☐ Nervous disorders
- ☐ Mental disorders
- ☐ Currently taking blood thinner
- ☐ Currently taking medication for osteoporosis
- ☐ Alcoholism
- ☐ Use tobacco products
- ☐ Use recreational drugs, including cocaine

Has any doctor prescribed an antibiotic before having any dental treatment? ☐ Yes ☐ No

If yes, for what reason? _____

Does anyone in your family have a history of:

☐ Diabetes ☐ High Blood Pressure ☐ Low Blood Pressure ☐ Heart disease ☐ Cancer

Female patients: Are you pregnant? ☐Yes ☐ No If yes, when is your due date? _____

Is there any other information that would be important to your dental or medical health? _____

_____

Previous dentist: _____ Date of last visit & reason: _____

Reason for today's visit: _____

Whom may we thank for referring you to our office? _____

Signature: _____ Date: _____

Patient Questionnaire

Please answer the following questions:
Are you having discomfort at this time? ☐Yes ☐No
Does dental treatment make you nervous? ☐ No ☐ Slightly ☐ Moderately ☐ Extremely
Have you ever been treated for periodontal disease (gum disease)? ☐ Yes ☐ No
How often do you brush your teeth? _____ How often do you floss? _____
What kind of brush do you use? ☐ Soft ☐ Medium ☐ Hard ☐ Electric ☐ Battery powered ☐ Manual

Do you have or have you ever had any of the following? Please check all that apply.

- ☐ Bleeding sore gums
- ☐ Unpleasant taste/bad breath
- ☐ Burning tongue/lips
- ☐ Frequent blister, lips/mouth
- ☐ Swelling/lumps in mouth
- ☐ Ortho treatments (braces)
- ☐ Biting cheeks/lips
- ☐ Clicking/popping jaw
- ☐ Difficulty open/closing jaw
- ☐ Change/shifting in bite
- ☐ Do you use fluoride rinse
- ☐ Gag easily
- ☐ Loose teeth
- ☐ Sensitive to hot
- ☐ Sensitive to cold
- ☐ Sensitive to sweets
- ☐ Sensitive to biting
- ☐ Food impaction
- ☐ Clenching/grinding
- ☐ Teeth removed/extracted

These are the things that are most important to me about my dental treatment: _____

_____

What do you fear most about dental care? _____

My mouth is: ☐ very comfortable ☐ moderately comfortable ☐ uncomfortable
I think my present state of dental health is: ☐ excellent ☐ good ☐ poor
I:

- ☐ think the appearance of my mouth is excellent
- ☐ am satisfied with the appearance of my mouth
- ☐ am dissatisfied with the appearance of my mouth

- ☐ will do anything to keep natural teeth
- ☐ want to keep my teeth but have a certain budget of time and money that I am willing to spend on them

- ☐ have set goals for my oral health with a previous dentist
- ☐ want to set goals concerning my dental health

- ☐ have always done the best that was recommended for my dental health
- ☐ have not done what the dentists have recommended to me
- ☐ rarely go, and don't care much about having any dental work completed

- ☐ have put dentistry for myself and family high on my priority list
- ☐ put dentistry for myself and my family low on my priority list
- ☐ dentistry is somewhere on my list but it's hard to find

Please check any items you would like additional information on:

- ☐ Teeth replacement options
- ☐ Invisalign or braces
- ☐ Zoom whitening for whitening options
- ☐ Financing/payment options
- ☐ Sedation options