Patient Information

Confidential Information Questionnaire

Patient Legal Last Name _____

First Name _____

M.I. _____

Date Of Birth _____

Sex ☐**Male** ☐**Female**

Social Security # _____

Prefer to Be Called ☐**Home** ☐**Cell** ☐**Work**

Home Phone Number _____

Cell Phone Number _____

Work Phone Number _____

Patient's Address

Address _____

Address 2 _____

City _____

State _____

Zip _____

Email _____

Marital Status

☐**Single** ☐**Married** ☐**Divorced** ☐**Under 18**

Patient's/Guardian's Employer _____

Occupation _____

Employer

Employer Name _____

Phone Number _____

Emergency Contact Information

Person We May Contact In Case of an Emergency (Other Than Your Family Home)

Name _____

Relationship _____

Home Phone Number _____

Work Phone Number _____

Cell Phone Number _____

Insurance and Financial Information

Insurance Coverage ☐**Yes** ☐**No**

Insurance Company Name _____

Insurance Address _____

Insurance Phone _____

Subscriber's Name _____

Patient's Relationship to Subscriber ☐**Self** ☐**Spouse** ☐**Dependent**

Subscriber's Birthday _____

Subscriber's SSN / ID # _____

Group / Program Number _____

Employer (If Different from above) _____

Employer's Address _____

Secondary Coverage

Insurance Name _____

Insurance Address _____

Insurance Phone _____

Subscriber's Name _____

Patient's relationship to Subscriber ☐**Self** ☐**Spouse** ☐**Dependent**

Subscriber's Birthday _____

Subscriber's SSN / ID # _____

Group / Program Number _____

Employer (If Different from above) _____

Employer Address _____

Release Information

You May Discuss My Healthcare With

Health Care Providers ☐**Yes** ☐**No** Insurance Companies ☐**Yes** ☐**No**

Referral Information

Whom may we thank for referring you to our practice?

☐ Postcard to House ☐Other

☐ Website/Internet Search ☐Referral

☐ Saw Office While in Buiding (Walk In) Name: _____

Assignment & Release

I hereby authorize my insurance benefits to be paid directly to the dentists. I am financially responsible for any balances due and authorize the dentists to release any information for this claim. I authorize that my records can be used by the doctor if he/she so determines. In consideration of the services rendered to me by this dental office, I am obligated to pay said office in accordance with its credit terms and policy.

I consent to making of videotapes, photographs, and x-rays before, during, and after treatment, and to use the same by the doctor in scientific papers or demonstrations. I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

_____

Signature-Patient/Guardian Date

Medical History Form

Medical History

Do you have or have you ever had:

Hospitalization for illness or injury ☐YES ☐NO

An allergic reaction to

☐ **Asprin**	☐ **Sulfa**
☐ **Ibuprofen**	☐ **Local anesthetic**
☐ **Acetaminophen**	☐ **Fluoride**
☐ **Codeine**	☐ **Metals** (nickel, gold, silver)
☐ **Penicillin**	☐ **Latex**
☐ **Erythromycin**	☐ **Other**
☐ **Tetracycline**	

Heart problems, or cardiac stent within the last six months ☐YES ☐NO
History of infective endocarditis ☐YES ☐NO
Artificial heart valve, repaired heart defect (PFO) ☐YES ☐NO
Pacemaker or implantable defibrillator ☐YES ☐NO
Artificial prothesis (heart valve or joint) ☐YES ☐NO
Rheumatic or scarlet fever ☐YES ☐NO
High or low blood pressure ☐YES ☐NO
A stroke (taking blood thinners) ☐YES ☐NO
Anemia or other blood disorder ☐YES ☐NO
Prolonged bleeding due to a slight cut (INR> 3.5) ☐YES ☐NO
Emphysema, scarcoidosis ☐YES ☐NO
Tuberculosis ☐YES ☐NO
Asthma ☐YES ☐NO
Breathing or sleep problems (I.E. snoring, sinus) ☐YES ☐NO
Kidney disease ☐YES ☐NO
Liver disease ☐YES ☐NO
Jaundice ☐YES ☐NO
Thyroid, parathyroid disease, or calcium deficiency ☐YES ☐NO
Hormone defiency ☐YES ☐NO
High Cholesterol or taking statin drugs ☐YES ☐NO
Diabetes (HbA1c=____) ☐YES ☐NO
Stomach or duodenal ulcer ☐YES ☐NO
Digestive disorders (I.E. gastic reflux) ☐YES ☐NO
Osteoporosis/ osteopenia (i.e. taking bisphosphonates) ☐YES ☐NO
Arthritis ☐YES ☐NO
Glaucoma ☐YES ☐NO
Contact lenses ☐YES ☐NO
Head or neck injuries ☐YES ☐NO
Epilepsy, convulsions (seizures) ☐YES ☐NO
Neurologic problems (attention deficit disorder) ☐YES ☐NO
Viral infections and cold sores ☐YES ☐NO
Any lumps or swelling in the mouth ☐YES ☐NO
Hives, skin rash, hay fever ☐YES ☐NO

STI/STD ☐YES ☐NO
Hepatitis ☐YES ☐NO
HIV/AIDS ☐YES ☐NO
Tumor, abnormal growth ☐YES ☐NO
Radiation therapy ☐YES ☐NO
Chemotherapy ☐YES ☐NO
Emotional problems ☐YES ☐NO
Psychiatric treatment ☐YES ☐NO
Antidepressant medication ☐YES ☐NO
Alcohol/street drug use ☐YES ☐NO

Do you have or have you ever had:

Presently being treated for any other illness ☐YES ☐NO
Aware of a change in our health (i.e. fever, new cough) ☐YES ☐NO
Taking medication for weight management (I.E. fen-phen) ☐YES ☐NO
Taking dietary supplement ☐YES ☐NO
Often exhausted or fatigued ☐YES ☐NO
Experiencing frequent headaches ☐YES ☐NO
A smoker, smoked previously or use smokeless tobacco ☐YES ☐NO
Considered a touchy person ☐YES ☐NO
Often unhappy or depressed ☐YES ☐NO
FEMALE-taking birth control pills ☐YES ☐NO
FEMALE- pregnant ☐YES ☐NO
MALE- prostate disorders ☐YES ☐NO

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possible affect your dental treatment. (I.E. Botox, Collagen Injections):

List all medications, supplements, and or vitamins taken within the last two years

Please advise us in the future of any change in your medical history or any medications you may be taking.

Signature-Patient/Guardian Date

Dental History Form

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? ☐**3mo.** ☐**4mo.** ☐**6mo.** ☐**12mo.** ☐**Not routinely**

What is your immediate concern? _____

Please Answer the following:

Personal History

Are you fearful of dental treatment? ☐**YES** ☐**NO**

How fearful on a scale of 1 (least) to 10 (most)
☐**1** ☐**2** ☐**3** ☐**4** ☐**5** ☐**6** ☐**7** ☐**8** ☐**9** ☐**10**

Have you had an unfavorable dental experience? ☐**YES** ☐**NO**

Have you ever had complications from past dental treatment? ☐**YES** ☐**NO**

Have you ever had trouble getting numb or had any reactions to local anesthetic? ☐**YES** ☐**NO**

Did you ever have braces, orthodontic treatment or had your bite adjusted? ☐**YES** ☐**NO**

Have you had any teeth removed? ☐**YES** ☐**NO**

Smile Characteristics

Is there anything about the appearance of your teeth that you would like to change? ☐**YES** ☐**NO**

Have you ever whitened (bleached) your teeth? ☐**YES** ☐**NO**

Have you felt uncomfortable or self conscious about the appearance of your teeth? ☐**YES** ☐**NO**

Have you been disappointed with the appearance of previous dental work? ☐**YES** ☐**NO**

Bite and Jaw Joint

Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) ☐**YES** ☐**NO**

Do you / would you have any problem chewing gum? ☐**YES** ☐**NO**

Do you / would you have any problems chewing bagels, baguettes, protein bars, or other hard foods? ☐**YES** ☐**NO**

Have your teeth changed in the last 5 years, become shorter, thinner or worn? ☐**YES** ☐**NO**

Are your teeth crowding or developing spaces? ☐**YES** ☐**NO**

Do you have more than one bite and squeeze to make your teeth fit together? ☐**YES** ☐**NO**

Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? ☐**YES** ☐**NO**

Do you clench your teeth in the daytime or make them sore? ☐**YES** ☐**NO**

Do you have any problems with sleep or wake up with an awareness of your teeth? ☐**YES** ☐**NO**

Do you wear or have you ever worn a bite appliance? ☐**YES** ☐**NO**

Tooth Structure

Have you had any cavities within the past 3 years? ☐**YES** ☐**NO**

Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? ☐**YES** ☐**NO**

Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? ☐**YES** ☐**NO**

Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? ☐**YES** ☐ **NO**

Do you have grooves or notches on your teeth near the gum line? ☐**YES** ☐**NO**

Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? ☐**YES** ☐**NO**

Do you frequently get food caught between any teeth? ☐**YES** ☐**NO**

Gum and Bone

Do your gums bleed or are they painful when brushing or flossing? ☐**YES** ☐**NO**

Have you ever been treated for gum disease or been told you have lost bone around your teeth? ☐**YES** ☐**NO**

Have you ever noticed an unpleasant taste or odor in your mouth? ☐**YES** ☐**NO**

Is there anyone with a history of periodontal disease in your family? ☐**YES** ☐**NO**

Have you ever experienced gum recession? ☐**YES** ☐**NO**

Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? ☐**YES** ☐**NO**

Have you experienced a burning sensation in your mouth? ☐**YES** ☐**NO**

_____

Patient's Signature Date

_____

Doctor's Signature Date