

# Patient Information

Name \_\_\_\_\_ Name you go by \_\_\_\_\_ Social Security \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ E-Mail \_\_\_\_\_

Birthdate \_\_\_\_\_ Sex \_\_\_\_F \_\_\_\_ M

Whom may we thank for referring you? \_\_\_\_\_

Patient Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Family physician(s) \_\_\_\_\_ Last physical \_\_\_\_\_

Physician's Address/Phone Number \_\_\_\_\_

In case of emergency, Contact person \_\_\_\_\_ Phone Number \_\_\_\_\_

# Authorization

## Privacy Act

I acknowledge notification and receipt of the Notice of Privacy Practice.

I give consent to use or disclose protected health information to another family member in order to carry out treatment, payment and healthcare operations. (please list name(s)

Name

Relationship

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I authorize use of my name to be printed in the newsletter either as "being welcomed as a new patient or being thanked for referring a patient",

I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered.

I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Patient or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

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# Health Update

Has there been any change in your general health in the past year? (allergies, new medications, vitamins)

YES NO Date \_\_\_\_\_ Describe: \_\_\_\_\_

YES NO Date \_\_\_\_\_ Describe: \_\_\_\_\_

YES NO Date \_\_\_\_\_ Describe: \_\_\_\_\_

YES NO Date \_\_\_\_\_ Describe: \_\_\_\_\_

YES NO Date \_\_\_\_\_ Describe: \_\_\_\_\_

# Health Questionnaire

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Present Health Status: (Circle one)    EXCELLENT            GOOD            FAIR            POOR            DON'T KNOW

- YES    NO    Have you had a serious illness, operation or hospitalization during the past five years? If yes, please describe:  
\_\_\_\_\_
- YES    NO    Are you taking or have you recently taken any prescribed medication or inhalers? (please list medication & reason)  
\_\_\_\_\_
- YES    NO    Over the counter medication, natural or herbal preparations? \_\_\_\_\_
- YES    NO    Have you ever taken Pondimin (Fendluramine), Phen-Fen (Phentermine) or Redux (Dexphenfluramine) for weight loss?  
\_\_\_\_\_
- YES    NO    Has your physician told you to take antibiotics prior to having any type of dental procedure? If so, why?  
\_\_\_\_\_What do you take?\_\_\_\_\_
- YES    NO    Are allergic to any medication, drugs, latex or iodine? \_\_\_\_\_
- YES    NO    Have you ever had an adverse reaction to any drugs, anesthetics, sedatives, narcotics, aspirin, ibuprofen (Motrin)  
\_\_\_\_\_
- YES    NO    Have you ever had excessive bleeding that required special treatment? \_\_\_\_\_
- YES    NO    Have you been diagnosed as having immunodeficiency, systemic Lupus, or Aids? \_\_\_\_\_
- YES    NO    Is there a history of Diabetes in your family? \_\_\_\_\_
- YES    NO    Are you required, due to health, to restrict your work or activity in any way? \_\_\_\_\_
- YES    NO    Are you on a special or restricted diet of any kind? \_\_\_\_\_
- YES    NO    Do you use any kind of tobacco? If so, how much: \_\_\_\_\_ per day, week, month    How long? \_\_\_\_\_
- YES    NO    Do you use any kind of alcohol? If so, how much: \_\_\_\_\_ per day, week, month    How long? \_\_\_\_\_
- YES    NO    Do you have any history of substance abuse or do you currently use recreational drugs?  
\_\_\_\_\_

Check the following that applies to you:

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> chest pain upon exertion  | <input type="checkbox"/> hepatitis or jaundice      | <input type="checkbox"/> colitis                    | <input type="checkbox"/> sleep apnea                |
| <input type="checkbox"/> shortness of breath       | <input type="checkbox"/> elevated cholesterol       | <input type="checkbox"/> diabetes                   | <input type="checkbox"/> asthma                     |
| <input type="checkbox"/> high blood pressure       | <input type="checkbox"/> neurological disorders     | <input type="checkbox"/> Crohn's disease            | <input type="checkbox"/> bronchitis                 |
| <input type="checkbox"/> low blood pressure        | <input type="checkbox"/> stroke                     | <input type="checkbox"/> radiation therapy          | <input type="checkbox"/> emphysema                  |
| <input type="checkbox"/> heart valve prosthesis    | <input type="checkbox"/> headaches                  | <input type="checkbox"/> chemotherapy               | <input type="checkbox"/> sinus problems             |
| <input type="checkbox"/> mitral valve prolapse     | <input type="checkbox"/> received blood transfusion | <input type="checkbox"/> history of cancer          | <input type="checkbox"/> persistent cough           |
| <input type="checkbox"/> congenital heart lesion   |   |   | <input type="checkbox"/> tuberculosis               |
| <input type="checkbox"/> rheumatic fever           | <input type="checkbox"/> impaired liver function    | <input type="checkbox"/> migraines                  |   |
| <input type="checkbox"/> heart murmur              | <input type="checkbox"/> kidney disease             | <input type="checkbox"/> epilepsy                   |   |
| <input type="checkbox"/> damaged heart valve       | <input type="checkbox"/> impaired kidney function   | <input type="checkbox"/> seizures                   | <input type="checkbox"/> glaucoma                   |
| <input type="checkbox"/> heart arrhythmia          | <input type="checkbox"/> esophageal reflux          | <input type="checkbox"/> mental health problems     | <input type="checkbox"/> contact lenses             |
| <input type="checkbox"/> tachycardia               | <input type="checkbox"/> hiatal hernia              |   | <input type="checkbox"/> severely impaired vision   |
| <input type="checkbox"/> heart surgery             | <input type="checkbox"/> G.I. Ulcers                | <input type="checkbox"/> joint replacement surgery  |   |
| <input type="checkbox"/> cardiac pacemaker         | <input type="checkbox"/> anorexia or bulimia        | <input type="checkbox"/> arthritis                  | <input type="checkbox"/> cold sores, fever blisters |
| <input type="checkbox"/> cerebral vascular disease | <input type="checkbox"/> irritable bowel syndrome   | <input type="checkbox"/> connective tissue disorder |   |

Do you have any disease, problem or condition that is not listed above? If so, please explain:  
\_\_\_\_\_

**For women**, check all that apply:     I am pregnant     I am nursing     I am taking birth control pills

# Dental History

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Are you presently satisfied with the condition of your mouth and teeth? (circle one)

VERY SATISFIED    SATISFIED    IT'S OK    SOMEWHAT DISSATISFIED    VERY DISSATISFIED

What level of dental health do you aspire to? (circle one)

EXCELLENT    GOOD    FAIR    NOT IMPORTANT

What do you feel is your current level of dental health? (circle one)

EXCELLENT    GOOD    FAIR    NOT IMPORTANT

How would you rate your smile at this time? (circle one)

EXCELLENT    GOOD    FAIR    NOT IMPORTANT

How would you like to see your smile? (circle one)

EXCELLENT    GOOD    FAIR    NOT IMPORTANT

Any dental fears or significant past dental experience? \_\_\_\_\_

## What are your goals or priorities for the health, function and appearance of your teeth and mouth?

(rate each item 1-5 with 1 being your lowest priority and 5 your highest—you can use the same number more than once)

\_\_\_\_\_ Be able to chew food and eat what I want

\_\_\_\_\_ Be free of mouth pain and tenderness

\_\_\_\_\_ Preserve my teeth and avoid dentures

\_\_\_\_\_ For my mouth to look nice when I smile

\_\_\_\_\_ Be free of infection

\_\_\_\_\_ Have a healthy and hassle-free mouth

YES    NO    Please describe any discomforts, pain or concerns related to your mouth?  
\_\_\_\_\_

YES    NO    Are you currently aware of any infection in your mouth? If yes, please describe:  
\_\_\_\_\_

YES    NO    Do your gums ever bleed? If so, when? \_\_\_\_\_

YES    NO    Do you have a problem with bad breath or have any friends or family made you aware of this?  
\_\_\_\_\_

YES    NO    Are you interested in replacing lost teeth?

YES    NO    Are any of your teeth tender when you chew hard foods?

YES    NO    Are any of your teeth sensitive to cold, hot sweets, certain foods or drinks? If yes, please describe:  
\_\_\_\_\_

YES    NO    Are you aware of gum recession around any of your teeth?

## Dental History (continued)

YES NO Would you like to discuss any of the following? (please check)

- |   |   |
|---|---|
| <input type="checkbox"/> missing teeth          | <input type="checkbox"/> drill-less dentistry               |
| <input type="checkbox"/> implants               | <input type="checkbox"/> air abrasion (decay removal)       |
| <input type="checkbox"/> veneers                | <input type="checkbox"/> porcelain crowns                   |
| <input type="checkbox"/> old silver fillings    | <input type="checkbox"/> whitening your teeth               |
| <input type="checkbox"/> tooth colored fillings | <input type="checkbox"/> straightening teeth without braces |
| <input type="checkbox"/> color of teeth         |   |

Check any of the following that describe you or makes dental treatment easier for you:

- I tolerate most dental care reasonably well.
- I tolerate injections in my mouth well.
- I am fearful of dental injections.
- I prefer to be medicated to relax, or sedated for treatment.
- I have a hard time sitting in the dental chair for more than an hour.
- I have difficulty keeping my mouth open wide.

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Overall long-term goals (to be filled out by doctor)

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# Smile Assessment

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please consider each statement carefully and circle YES or NO. The doctor and members of the dental team will discuss your responses with you in confidence.

- |   |     |    |
|---|-----|----|
| 1. I am concerned about the appearance of my teeth or smile.                              | YES | NO |
| 2. I am concerned about the whiteness/lack of whiteness of one or more of my teeth.       | YES | NO |
| 3. I am concerned about the position or angle of one or more my teeth.                    | YES | NO |
| 4. I am concerned about the shape of one or more of my teeth.                             | YES | NO |
| 5. In social situations, I am sometimes embarrassed by my teeth or my smile.              | YES | NO |
| 6. There are some things about my upper front teeth that I would like to change.          | YES | NO |
| 7. There are some things about my lower front teeth that I would like to change.          | YES | NO |
| 8. I have old fillings or previous dental treatment that is no longer satisfactory to me. | YES | NO |
| 9. My bite is sometimes uncomfortable when chewing or biting.                             | YES | NO |
| 10. I am interested in learning more about esthetic dentistry.                            | YES | NO |
| 11. I have spaces or missing teeth that I am aware of.                                    | YES | NO |

Please use the space below to indicate any other problems, concerns, or questions. We will make every effort to listen attentively to your concerns so that we can present you with the best possible treatment options. Thank You.

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