

It is important for us to know about your dental and medical history. Many things have a direct bearing on your dental health. I will review this questionnaire and discuss it with you in detail. Information you give me is strictly confidential and will not be released to anyone without your written permission.

Name				Date
Address		City	State Zip	Telephone (home)
Occupation				Telephone (work)
Marital Status		Date of Birth	Social Security #	
Physicians			Have family & friends been treated here?	
Previous Dentist			Referred By	
Reason for Changing				
Dental Insurance Company		Group #	Insured's Name	
Address		City	State Zip	Insured's Social Security #

Your Current Dental Needs (Check All That Apply)

- | | | |
|---------------------|--------------------|-----------------|
| * Emergency (pain) | * Partial Dentures | * Fillings |
| * Routine Exam | * Full Dentures | * Gum Treatment |
| * Cleaning of Teeth | * Crowns | * Root Canal |
| * Extractions | * Bridges | * Orthodontics |

My main dental problem now is:

Do you fear dental treatment?	Yes__ No__	Date of last dental cleaning_____
Have you ever been treated for periodontal disease (pyorrhea)?	Yes__ No__	How many times have you had your teeth cleaned in the past 3 years? ___
Do your gums bleed?	Yes__ No__	Are your teeth sensitive to Hot_____
Do you have difficulty chewing your food?	Yes__ No__	Cold_____ Sweet_____?
Do you grind or clench your teeth?	Yes__ No__	Are you satisfied with the appearance of your teeth? Yes___ No___
Do you have a bite guard/splint?	Yes__ No__	If no, why not?_____
Are spaces developing between your teeth?	Yes__ No__	Have you had gum boils or
Have you noticed your bite changing?	Yes__ No__	swelling?___
Has a dentist or hygienist shown you how to clean your teeth?	Yes__ No__	If yes, do you use this method of cleaning your teeth now? Yes__ No__
swelling?___	Yes__ No__	Do you have frequent cold sores? Yes__ No__
If yes, do you use this method of cleaning your teeth now?	Yes__ No__	How would you rate your past dental care? Good___ Fair___ Poor___
Do you have frequent cold sores?	Yes__ No__	Do you desire nitrous oxide sedation during treatment? Yes___ No___
Have you had orthodontic treatment to straighten your teeth?	Yes__ No__	How often do you brush? _____
Have you ever had problems with extractions?	Yes__ No__	Do you floss? Yes__ No__ How often?__
Does food wedge between your teeth?	Yes__ No__	Do you use a fluoride rinse? Yes__ No__
Has any member of your family lost all their teeth?	Yes__ No__	Is your toothbrush Soft__ Med__ Hard__
Would you be tremendously disturbed to lose all of your teeth?	Yes__ No__	

DENTAL HISTORY NOTE AND UPDATES: _____

MEDICAL HISTORY

DO YOU HAVE OR HAVE YOU EVER HAD

- Hepatitis, jaundice or liver disease Yes__ No__ ?__
- Epilepsy, convulsions or fainting spells Yes__ No__ ?__
- Rheumatic fever Yes__ No__ ?__
- Heart murmur Yes__ No__ ?__
- Heart trouble or stroke Yes__ No__ ?__
- High or low blood pressure Yes__ No__ ?__
- Shortness of breath Yes__ No__ ?__
- Chest pains Yes__ No__ ?__
- Swelling in ankles Yes__ No__ ?__
- Tuberculosis Yes__ No__ ?__
- Kidney disease or infection Yes__ No__ ?__
- Diabetes Yes__ No__ ?__
- Arthritis or rheumatism Yes__ No__ ?__
- Stomach or duodenal ulcers Yes__ No__ ?__
- Medical radiation treatment Yes__ No__ ?__
- Glaucoma Yes__ No__ ?__
- Asthma, hay fever or allergies Yes__ No__ ?__
- Drug reaction to codeine/penicillin Yes__ No__ ?__
- Drug reaction to tetracycline - Demerol, valium, erythromycin Yes__ No__ ?__
- Percocet, nitrous oxide, percodan Yes__ No__ ?__
- Barbituates, aspirin, other Yes__ No__ ?__
- Veneral disease Yes__ No__ ?__
- Surgery Yes__ No__ ?__
- Hospitalization for illness/surgery Yes__ No__ ?__
- Hives or skin rash Yes__ No__ ?__
- Cancer or abnormal growths Yes__ No__ ?__
- Anemia or blood disorder Yes__ No__ ?__
- Abnormal bleeding problems Yes__ No__ ?__
- AIDS, ARC, ALS Yes__ No__ ?__
- HIV Infection Yes__ No__ ?__
- Emphysema Yes__ No__ ?__
- Arteriosclerosis Yes__ No__ ?__
- Thyroid or parathyroid disease Yes__ No__ ?__
- An artificial joint (hip, knee...) Yes__ No__ ?__

- Psychotherapy or counseling Yes__ No__ ?__
- Alcoholism Yes__ No__ ?__
- Other chemical addictions Yes__ No__ ?__
- Any illness not listed Yes__ No__ ?__

ARE PRESENTLY:

- Under a physicians care Yes__ No__ ?__
- Taking any medication Yes__ No__ ?__
- or within last year Yes__ No__ ?__
- Taking vitamins Yes__ No__ ?__
- Allergic to dental anesthetic Yes__ No__ ?__
- Aware of recent weight change Yes__ No__ ?__
- Under unusual stress Yes__ No__ ?__
- Under emotional tension Yes__ No__ ?__
- Treatment for stress Yes__ No__ ?__
- Treatment for emotional tension Yes__ No__ ?__
- Do you bruise easily Yes__ No__ ?__
- Do you wear contact lenses Yes__ No__ ?__
- Do you smoke Yes__ No__ ?__
- If yes, how much _____

IF FEMALE - ARE YOU NOW

- Pregnant Yes__ No__ ?__
- Taking anti-pregnancy drug Yes__ No__ ?__
- Presently in menopause Yes__ No__ ?__
- Post menopause Yes__ No__ ?__
- Menstrual cycle issues Yes__ No__ ?__

MAY WE REQUEST YOUR RECORDS Yes__ No__

DENTAL/MEDICAL HISTORY NOTES: _____

ANYTHING YOU WOULD LIKE TO ADD: _____

To the best of my knowledge, all of the preceding answers are true and correct. I agree to assume full financial responsibility for all treatment rendered.

Signature of Patient, Parent or Guardian

Date