



WELCOME
Help us to get to
KNOW YOU BETTER

Name _____ Mr. Mrs. Miss Ms. Dr.

Telephone # (H) _____ (B) _____ Email _____

Address _____ Town _____ Postal Code _____

Date of Birth ____/____/____ (M/D/Y) Emergency Contact Person _____

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

Marital Status _____ Children's Names and Ages _____

Occupation _____ Employer _____

Business Address _____ Telephone # _____

Spouse's Name _____ Employer _____ Telephone# _____

Name of family member responsible for your account _____

Do you have Dental Insurance? _____ Name of Insurance Company _____

OFFICE POLICY

Your appointment time will be reserved especially for you. If you are unable to keep the appointment, we require two business days notice.

Our policy is that services are paid for at each visit, as they are performed. However, in certain circumstances, financial arrangements may be made. We accept all methods of payment including: VISA, MC, AMEX, debit, cash, cheque or insurance assignment.

Date _____

Signature _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? Excellent Good Fair Poor

HAVE YOU EVER HAD THE FOLLOWING: YES NO

- 1. hospitalization for illness or injury.....
- 2. allergic reaction to
 - aspirin, ibuprofen, acetaminophen
 - penicillin
 - erythromycin
 - tetracycline
 - codeine
 - local anesthetic
 - fluoride
 - metals (gold, stainless steel)
 - latex
 - any other medications _____
- 3. heart problems.....
- 4. heart murmur.....
- 5. rheumatic fever.....
- 6. scarlet fever.....
- 7. high blood pressure.....
- 8. low blood pressure.....
- 9. a stroke.....
- 10. artificial prosthesis (i.e. heart valve or joints).....
- 11. anemia or other blood disorder.....
- 12. prolonged bleeding due to a slight cut.....
- 13. emphysema.....
- 14. tuberculosis.....
- 15. asthma.....
- 16. sinus problems.....
- 17. kidney disease.....
- 18. liver disease.....
- 19. jaundice.....
- 20. thyroid or parathyroid disease.....
- 21. hormone deficiency.....
- 22. high cholesterol.....
- 23. diabetes.....
- 24. stomach or duodenal ulcer.....

- 25. digestive disorders.....
- 26. arthritis.....
- 27. glaucoma.....
- 28. contact lenses.....
- 29. head or neck injuries.....
- 30. epilepsy, convulsions (seizures).....
- 31. viral infections and cold sores.....
- 32. any lumps or swelling in the mouth.....
- 33. hives, skin rash, hay fever.....
- 34. venereal disease.....
- 35. hepatitis (type ____).....
- 36. HIV / AIDS.....
- 37. tumor, abnormal growth.....
- 38. radiation therapy.....
- 39. chemotherapy.....
- 40. emotional problems.....
- 41. psychiatric treatment.....
- 42. antidepressant medication.....
- 43. alcohol / drug dependency.....

ARE YOU:

- 44. presently being treated for any other illness.....
- 45. aware of a change in your general health.....
- 46. taking medication for osteoporosis/osteopenia ..
- 47. often exhausted or fatigued.....
- 48. subject to frequent headaches.....
- 49. a heavy smoker (1 pack or more a day).....
- 50. considered a touchy person.....
- 51. often unhappy or depressed.....
- 52. easily upset or irritated.....
- 53. FEMALE - taking birth control pills.....
- 54. FEMALE - pregnant.....
- 55. MALE - Prostate disorders.....

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment

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

Drug	Purpose	Drug	Purpose

Ask for an additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____



DENTAL HISTORY

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: 3 mo. 4 mo. 6 mo. 12 mo. Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES NO**

Personal History

- 1. Are you fearful of dental treatment? Scale of 1 to 10 (very) _____
- 2. Have you had an unfavorable dental experience?.....
- 3. Have you ever had complications from past dental treatment?.....
- 4. Have you ever had trouble getting numb or reactions to local anesthetic?.....
- 5. Did you ever have braces, orthodontic treatment or had your bite adjusted?.....
- 6. Have you had any teeth removed?.....

Smile Characteristics

- 7. Is there anything about the appearance of your teeth that you would like to change?.....
- 8. Have you ever whitened (bleached) your teeth?.....
- 9. Are you self conscious about your teeth?.....
- 10. Have you been disappointed with the appearance of previous dental work?.....

Bite and Jaw Joint

- 11. Do you / would you have any problems chewing gum?
- 12. Do you / would you have any problems chewing bagels or other hard foods?.....
- 13. Have your teeth changed in the last 5 years, become shorter, thinner or worn?.....
- 14. Are your teeth crowding or developing spaces?.....
- 15. Do you have more than one bite or do you clench (squeeze) to make your teeth fit together?.....
- 16. Do you have any problems with sleep or wake up with an awareness of your teeth?.....
- 17. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping).....
- 18. Do you have tension headaches or sore teeth?.....
- 19. Do you wear or have you ever worn a bite appliance?.....

Tooth Structure

- 20. Have you had any cavities within the past 3 years?.....
- 21. Do you have a dry mouth?.....
- 22. Are any teeth sensitive to hot, cold, biting or sweets?.....
- 23. Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth?.....
- 24. Do you avoid brushing any part of your mouth?.....

Gum and Bone

- 25. Have you ever been diagnosed or treated for periodontal (gum) disease?.....
- 26. Have you ever experienced gum recession?.....
- 27. Is there anyone with a history of periodontal disease in your family?.....
- 28. Do your gums bleed when brushing, flossing or eating?.....
- 29. Are your teeth becoming loose?.....
- 30. Have you ever noticed an unpleasant taste or odor in your mouth?.....
- 31. Have you experienced a burning sensation in your mouth?.....

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

PATIENT SELF EVALUATION FORM

1. How did you hear about our practice?
(Please tick all that apply)

- Referred by a friend/ family/ employee
(name _____)
- Radio ad
- Yellow Page ad
- Brochure
- Internet
- Newspaper
- Word of mouth
- I walked by or drove by the practice
- Other _____

2. Date of your last hygiene visit
(approximate is okay) _____

3. On a scale of 1 to 5 (1 being bad, 5 being good) please rate how you feel your overall dental health is:

1 2 3 4 5

4. On a scale of 1 to 5 (1 being bad, 5 being faithful), rate how faithfully you have had your teeth cleaned over the last ten years.

1 2 3 4 5

5. On a scale of 1 to 5 (1 being not sensitive, 5 being very sensitive), what is your level of sensitivity to dental procedures?

1 2 3 4 5

6. On a scale of 1 to 5 (1 being not sensitive, 5 being very sensitive), what is your level of sensitivity to cleaning visits?

1 2 3 4 5

7. Rate how you feel about your smile and the look of your teeth (1 being unhappy, 5 being very happy):

1 2 3 4 5

8. Are you interested in regular hygiene cleanings?

- Yes No

9. What is the main reason for your visit today?

- Tooth pain
- I need a check up
- Cleaning
- Orthodontics (braces)
- Whitening
- Cosmetic dentistry
- Sedation dentistry
- Other _____

10. I would like to learn more about:

- Orthodontics
- Whitening
- Cosmetic dentistry
- Sedation dentistry
- Implants
- Bridges, Veneers
- Dentures
- Other _____