

**WELCOME TO OUR OFFICE. IT IS OUR SINCERE HOPE THAT YOUR VISITS HERE WILL BE COMFORTABLE AND SATISFYING. PLEASE TAKE A FEW MINUTES TO COMPLETE THIS CONFIDENTIAL QUESTIONNAIRE SO THAT WE MAY BETTER SERVE YOU. PLEASE COMPLETE ALL SIDES OF THESE FORMS.**

DATE \_\_\_\_\_

Patient's Name \_\_\_\_\_ Birthday \_\_\_\_\_ Sex/M \_\_\_ F \_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

SS# \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

E-mail Address \_\_\_\_\_ Driver's License # \_\_\_\_\_ State of Issue \_\_\_\_\_

Employer \_\_\_\_\_ Occupaion \_\_\_\_\_ Phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Whom May We Thank for Referring You? \_\_\_\_\_

Spouse's Name \_\_\_\_\_ SS# \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

WHO WILL BE RESPONSIBLE FOR THIS ACCOUNT? Self \_\_\_\_\_ Other \_\_\_\_\_

Do You Have Dental Coverage? Yes \_\_\_ No \_\_\_ Name of Insured \_\_\_\_\_

Subscriber # \_\_\_\_\_ DOB of Insured \_\_\_\_\_ Group # \_\_\_\_\_

Name of Dental Benefit Company \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

**MEDICAL HISTORY** - Do you have or have had any of the following. If so, please circle.

Any Heart Problems	Yes	No	Scarlet Fever	Yes	No	Sinus Problems	Yes	No
Mitral Valve Prolapse	Yes	No	Radiation Treatment	Yes	No	Hepatitis A,B,C	Yes	No
Low Blood Pressure	Yes	No	Ulcer	Yes	No	Asthma	Yes	No
High Blood Pressure	Yes	No	Stroke	Yes	No	Rheumatic Fever	Yes	No
Cardiac Pacemaker	Yes	No	Epilepsy	Yes	No	Tuberculosis	Yes	No
Circulatory	Yes	No	Diabetes	Yes	No	Anemia	Yes	No
Excessive Bleeding	Yes	No	Venereal Disease	Yes	No	Nervous Problems	Yes	No
Aids/HIV	Yes	No	Tobacco Use	Yes	No	Other	Yes	No

ARE YOU PREGNANT? YES \_\_\_ NO \_\_\_ DO YOU TAKE BIRTH CONTROL PILLS? YES \_\_\_ NO \_\_\_

DO YOU HAVE A HISTORY OF CHEMICAL DEPENDENCY? YES \_\_\_ NO \_\_\_

If yes, how long have you been in recovery? \_\_\_\_\_

Have you taken any of the following in the last 24 hours: cocaine, ecstasy, and methamphetamine? \*Please be aware that if you have taken any of these drugs listed and we administer certain drugs, even anesthesia to you the following could occur: heart attack, stoke or death.

**MEDICAL HISTORY** continued

Do you drink coffee or tea? Yes \_\_\_\_ No \_\_\_\_ If yes, how often? \_\_\_\_\_

Please list any prescription medications you are currently taking: \_\_\_\_\_

Please list any over-the-counter medications or herbal medications you are currently taking: \_\_\_\_\_

***I AM ALLERGIC TO THE FOLLOWING***

***MEDICATION:*** \_\_\_\_\_

Comments: \_\_\_\_\_

1. What in particular, would you like for us to do for you? \_\_\_\_\_

2. When was your last dental check up? \_\_\_\_\_ Oral Cancer Screening? \_\_\_\_\_

Periodontal (gum) exam? \_\_\_\_\_

3. What can we do to insure your visits are as comfortable as possible?

4. Are any of your teeth sensitive to extreme temperatures? Yes \_\_\_\_ No \_\_\_\_

5. Are any of your teeth uncomfortable when chewing? Yes \_\_\_\_ No \_\_\_\_

6. Do you have a problem trapping food between any of your teeth? Yes \_\_\_\_ No \_\_\_\_

7. How often do you brush? \_\_\_\_\_ Floss? \_\_\_\_\_

8. Do your gums bleed when you brush? Yes \_\_\_\_ No \_\_\_\_ When you floss? Yes \_\_\_\_ No \_\_\_\_

9. Do you tear floss between any of your teeth? Yes \_\_\_\_ No \_\_\_\_

10. Do you have problems with breath odors? Yes \_\_\_\_ No \_\_\_\_ A bad taste in your mouth? Yes \_\_\_\_ No \_\_\_\_

11. On a scale of 1-10 where would you rank your smile? 1 2 3 4 5 6 7 8 9 10

Where would you like for it to be? 1 2 3 4 5 6 7 8 9 10

12. On a scale of 1-10, how important is your dental health to you? \_\_\_\_\_

On a scale of 1-10, where would you rank your current dental health? \_\_\_\_\_

On a scale of 1-10, where would you like for your dental health to be? \_\_\_\_\_

13. Do you think your dental health affects your overall health? Yes \_\_\_\_ No \_\_\_\_

14. Do you think it is important to have a dental exam and have your teeth cleaned professionally at least every 6 months? Yes \_\_\_\_ No \_\_\_\_

15. Which of the following, if any, would you like to improve on?

Color of your teeth \_\_\_\_ Chipped Teeth \_\_\_\_ Spaces \_\_\_\_

Crooked Teeth \_\_\_\_ Replace missing teeth \_\_\_\_ Worn teeth? \_\_\_\_

Replace old crowns or caps that don't match? \_\_\_\_

Replace black/silver fillings with tooth colored fillings \_\_\_\_

Gumline, show more or less gum? \_\_\_\_