Dental Health Services

WELCOME

Thank you for choosing our office for your continuing dental care. In order to serve you properly we will need the following information. All information is protected by the patient-doctor confidentiality. PLEASE PRINT.

Patient Information

Name: ____
(First) (MI) (Last) (Preferred Name)

Address: ____________________ City: ______________ State: _____ Zip: ________

Birthdate: ______________ SSN: ______________ Email: ____________________

Cell Phone: ____________ Home Phone: ____________ Work Phone: ____________

Check Appropriate Box: ☐ Male ☐ Female ☐ Unspecified ☐ Single ☐ Married ☐ Other ☐ Child

Patient or Parent's Employer: ____________________ Occupation: ______________

Parent/Guardian Name: ______________ Preferred way of contact: (circle one) *text email phone*

Emergency Contact: ______________ Relation: __________ Phone: ____________

How did you hear about our office? Friend: ___________ Internet: ________ Other: ________

Person Responsible for Account

Name of person responsible for this account: ____________________ Relation: __________

Insurance Information Policy holder's name: ______________ Relationship to patient: ________

Birthdate: __________ SSN: ____________ Insurance Company: ____________________

Name of employer: ____________________ Do you have any additional insurance? ☐ Yes ☐ No

Authorization to Release Information

Dental Health Services is authorized to discuss my dental care, appointments, and/or may release my confidential health information to the following:

Name: ______________________________ Relationship: ______________

Informed Consent and Acknowledgement

I consent to allow photographs and/or x-rays to be used for demonstrations, marketing material, patient education, etc. ☐ Full Face/Mouth ☐ Teeth/Jaw area only ☐ I refuse to share. _______ (initial)

I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions.

I have answered all questions regarding myself, or my dependent's medical history and present health condition fully and truthfully, including allergies. I also understand if there are any changes in health, I am to inform the doctor.

I agree to provide a minimum of 24 hour notice if I need to change my appointment for any reason. I understand if I fail an appointment I may be charged a fee. Failure to show for a second appointment may result in dismissal.

I instruct the dentist to deliver care that, in their professional judgement, is necessary in the restoration of my health once they've been discovered and discussed.

State and federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with a Notice of Privacy Practices. Our notice is available online. If you prefer a paper copy, please ask a team member for a copy of our Notice.

I acknowledge that a copy of the office's Notice of Privacy Practices has been made available to me.

______________________________ ______________________
Patient signature: (or guardian if patient is under 18) Date:

Dental History

How would you rate the condition of your mouth? ☐Excellent ☐Good ☐Fair ☐Poor

Previous dentist________________ Date of last dental exam __/__/____ Date of most recent Xrays __/__/____

I routinely see my dentist every ☐ 3 mo. ☐4 mo. ☐6 mo. ☐12 mo. ☐ Not routinely

Personal History ☐ ☐ ☐ Yes No

1. Are you fearful of dental treatment? How fearful, on a scale of 1(Least) to 10 (most) [___]________________ ☐ ☐
2. Have you has an unfavorable dental experience? ________________ ☐ ☐
3. Have you ever had complications from past dental treatment? ________________ ☐ ☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? ________________ ☐ ☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? ________________ ☐ ☐
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trama? _____ ☐ ☐

Gum and Bone ☐ ☐ ☐ Yes No

7. Do your gums bleed sometimes or are they ever painful when brushing or flossing? ________________ ☐ ☐
8. Have you ever been treated for gum disease, had scaling and root planing, or been told you have lost bon around your teeth? _____ ☐ ☐
9. Have you ever noticed an unpleasent taste or odor in your mouth? ________________ ☐ ☐
10. Is there anyone with a history of periodontal disease in your family ________________ ☐ ☐
11. Have you ever experienced gum recession, or can you see more of the roots of your teeth? ________________ ☐ ☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple _ ☐ ☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? ________________ ☐ ☐

Tooth Structure ☐ ☐ ☐ Yes No

14. Have you had any cavities within the past 3 years? ________________ ☐ ☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? ________________ ☐ ☐
16. Do you feel or notice any hokes (i.e pitting, craters) on the biting surface of your teeth? ________________ ☐ ☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth ________________ ☐ ☐
18. Do you have grooves or notches on your teeth near the gum line? ________________ ☐ ☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? ________________ ☐ ☐
20. Do you frequently get food caught between any teeth? ________________ ☐ ☐

Bite and Jaw Joint ☐ ☐ ☐ Yes No

21. Do you have problems with your jaw joint? (Pain, sounds, limited opening, locking, popping) ________________ ☐ ☐
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together? ________________ ☐ ☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?__ ☐ ☐
24. In the past 5 years, have your teeth changes (become shorter, thinner, or worn) or has your bite changed? ________________ ☐ ☐
25. Are your teeth becoming more crooked, crowded, or overlapped? ________________ ☐ ☐
26. Are your teeth developing spaces or becoming more loose? ________________ ☐ ☐
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together? ☐ ☐
28. Do you place your tongue between your teeth or close your teeth against your tongue? ________________ ☐ ☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? ________________ ☐ ☐
30. Do you clench or grind your teeth together in the daytime or make them sore? ________________ ☐ ☐
31. Do you have any problems with sleep (i.e restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?_ ☐ ☐
32. Do you wear or have you ever worn a bite appliance? ________________ ☐ ☐

Smile Characteristics ☐ ☐ ☐ Yes No

33. Is there anything abouyt the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (Shape, color, size, display) ________ ☐ ☐
34. Have you ever bleached (whitened) your teeth? ________________ ☐ ☐
35. Have you felt uncofortable or self consious about the appearance of your teeth? ________________ ☐ ☐
36. Have you been disappointed with the appearance of previous dental work? ________________ ☐ ☐

Medical History

Name of Phsician/ and their specialty? ____

Most recent physical examination ______________________ Purpose ____

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

Do you have or have you ever had: Yes No

Hospitalization for illness or injury___________ ☐ ☐
Yes No

1. Osetoporosis/ osteopenia oor ever taken anti-resorptive medications (e.g bisphosphonates) _ ☐ ☐
2. Arthritis or gout __________________________ ☐ ☐
3. Autoimmune disease (e.g rheumatoid arthritis, lupus, scleroderma) ______________________________ ☐ ☐
4. Glaucoma _______________________________ ☐ ☐
5. Contact lenses ___________________________ ☐ ☐
6. Head or neck injuries ______________________ ☐ ☐
7. Epilepsy, convulsons (seizures) ______________☐ ☐
8. Neurologic disorders (e.g alzheimer's disease, dementia, prion disease) __________________ ☐ ☐
9. Viral infections and cold sores _______________ ☐ ☐
10. Any lumps or swelling in the mouth___________ ☐ ☐
11. Hives, skin rash, hay fever_________________ ☐ ☐
12. STI/STD/HPV_____________________________ ☐ ☐
13. Hepatitis (type____) ________________________☐ ☐
14. HIV/AIDS ________________________________☐ ☐
15. Tumor, abnormal growth ___________________☐ ☐
16. Radiation therapy ___________________________☐ ☐
17. Chemotherapy, immunosuppressive medication☐ ☐
18. Emotional difficulties ______________________ ☐ ☐
19. Psychiatric treatment or antidepressant medication ☐ ☐
20. Concentration problems or ADD/ADHD ________ ☐ ☐
21. Alcohol/ recreational drug use ________________☐ ☐

Are you:

22. Presently being treated for any other illness____ ☐ ☐
23. Aware of a change in your health in the last 24 hours (e.g, fever, chills, new cough, or diarrhea) ______ ☐ ☐
24. Taking medications for weight management __ ☐ ☐
25. Taking diatary supplements, vitamins, and/ or probiotics________________________________ ☐ ☐
26. Often exhausted or fatigued_________________☐ ☐
27. Experiencing frequent headaches or chronic pain____☐ ☐
28. A smoker, smoked previously or other (e.g smokeless tobacco, vaping, e- cig, and cannabis) _________ ☐ ☐
29. Considered a touchy/ sensitive person ________ ☐ ☐
30. Often unhappy or depressed ________________ ☐ ☐
31. Taking birth control pills _____________________☐ ☐
32. Currently pregnant ___________________________☐ ☐
33. Diagnosed with a prostate disorder ___________☐ ☐
34. An allergic or bad reaction to any of the following:
    - Asprin, ibuprofen, acetaminophen, codine
    - Penicillin
    - Erythromycin
    - Tetracycline
    - Sulfa
    - Local anesthetic
    - Fluoride
    - Chlorhexidine (CHX)
    - Iodine
    - Metals (nickle, gold, silver)
    - Latex
    - Nuts
    - Fruit
    - Milk
    - Red dye
    - Other
35. Heart problems,or cardiac stent within the last 6 mo. ☐ ☐
36. History of infective endocarditis _________________ ☐ ☐
37. Artificial heart valve, repaired heart defect (PFO)____ ☐ ☐
38. Pacemaker or implantable defibrillator____________ ☐ ☐
39. Orthopedic or soft tissue implant (e.g joint replacement, breast implant_______________________________________ ☐ ☐
40. Heart mumur, rheumatic or scarlet fever _________ ☐ ☐
41. High or low blood pressure _____________________ ☐ ☐
42. A stroke (taking blood thinners) _________________ ☐ ☐
43. Anemia or other blood disorder __________________☐ ☐
44. Prolonged bleeding due to a slight cut (or INR > 3.5) ☐ ☐
45. Pneumonia, emphysema, shortness of breath, sarcoidosis ☐ ☐
46. Chronic ear infections, tuberculosis, measles, chicken pox ☐ ☐
47. Breathing problems (e.g asthma, stuffy nose, sinus congestion) ______________________________________ ☐ ☐
48. Sleep problems (e.g sleep apnea, snoring, insomnia, restless sleep, bedwetting) ______________________ ☐ ☐
49. Kidney disease _______________________________ ☐ ☐
50. Liver disease or jaundice ________________________ ☐ ☐
51. Vertigo (e.g "the room is spinning) _______________ ☐ ☐
52. Thyroid, parathyroid disease, or calcium deficiency _______ ☐ ☐
53. Hormone deficiency or imbalance (e.g poly cistic ovarian syndrome) ____________________________________ ☐ ☐
54. High cholesterol or taking statin drugs ____________ ☐ ☐
55. Diabetes (HbA1c =_____) _______________________ ☐ ☐
56. Stomach or duodenal ulcer ______________________ ☐ ☐
57. Digestive or eating disorders (e.g cliac disease, gastric reflux, bulimia, anorexia) ________________________☐ ☐

Describe any current medical treatment, impending surgery, genetic/ development delay, or other treatment that may possibly affect your dental treatment ____

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

____

Patients signature ____ Date_____________________