

# 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

- Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [ ] \_\_\_\_\_  YES  NO
- Have you had an unfavorable dental experience? \_\_\_\_\_  YES  NO
- Have you ever had complications from past dental treatment? \_\_\_\_\_  YES  NO
- Have you ever had trouble getting numb or had any reactions to local anesthetic? \_\_\_\_\_  YES  NO
- Did you ever have braces, orthodontic treatment or had your bite adjusted? \_\_\_\_\_  YES  NO
- Have you had any teeth removed? \_\_\_\_\_  YES  NO

## SMILE CHARACTERISTICS

- Is there anything about the appearance of your teeth that you would like to change? \_\_\_\_\_  YES  NO
- Have you ever whitened (bleached) your teeth? \_\_\_\_\_  YES  NO
- Have you felt uncomfortable or self conscious about the appearance of your teeth? \_\_\_\_\_  YES  NO
- Have you been disappointed with the appearance of previous dental work? \_\_\_\_\_  YES  NO

## BITE AND JAW JOINT

- Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) \_\_\_\_\_  YES  NO
- Do you / would you have any problems chewing gum? \_\_\_\_\_  YES  NO
- Do you / would you have any problems chewing bagels, baguettes, protein bars, or other hard foods? \_\_\_\_\_  YES  NO
- Have your teeth changed in the last 5 years, become shorter, thinner or worn? \_\_\_\_\_  YES  NO
- Are your teeth crowding or developing spaces? \_\_\_\_\_  YES  NO
- Do you have more than one bite and squeeze to make your teeth fit together? \_\_\_\_\_  YES  NO
- Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? \_\_\_\_\_  YES  NO
- Do you clench your teeth in the daytime or make them sore? \_\_\_\_\_  YES  NO
- Do you have any problems with sleep or wake up with an awareness of your teeth? \_\_\_\_\_  YES  NO
- Do you wear or have you ever worn a bite appliance? \_\_\_\_\_  YES  NO

## TOOTH STRUCTURE

- Have you had any cavities within the past 3 years? \_\_\_\_\_  YES  NO
- Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? \_\_\_\_\_  YES  NO
- Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? \_\_\_\_\_  YES  NO
- Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? \_\_\_\_\_  YES  NO
- Do you have grooves or notches on your teeth near the gum line? \_\_\_\_\_  YES  NO
- Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? \_\_\_\_\_  YES  NO
- Do you get food caught between any teeth? \_\_\_\_\_  YES  NO

## GUM AND BONE

- Do your gums bleed when brushing or flossing? \_\_\_\_\_  YES  NO
- Have you ever been treated for gum disease or been told you have lost bone around your teeth? \_\_\_\_\_  YES  NO
- Have you ever noticed an unpleasant taste or odor in your mouth? \_\_\_\_\_  YES  NO
- Is there anyone with a history of periodontal disease in your family? \_\_\_\_\_  YES  NO
- Have you ever experienced gum recession? \_\_\_\_\_  YES  NO
- Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? \_\_\_\_\_  YES  NO
- Have you experienced a burning sensation in your mouth? \_\_\_\_\_  YES  NO

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_



# CONFIDENTIAL INFORMATION QUESTIONNAIRE

PATIENT'S NAME		LAST	FIRST	MIDDLE	DATE OF BIRTH	SEX	SOCIAL SECURITY #
PATIENT'S ADDRESS		STREET	APT#	CITY	STATE	ZIP	EMAIL HOME PHONE
MARITAL STATUS <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> UNDER AGE 18		PATIENT'S/GUARDIAN'S EMPLOYER			OCCUPATION		
WORK ADDRESS		STREET	CITY	STATE	ZIP	CELL PHONE	WORK PHONE OK TO CALL WORK <input type="checkbox"/> YES <input type="checkbox"/> NO
SPOUSE'S NAME		LAST	FIRST	MIDDLE	SPOUSE'S EMPLOYER		OCCUPATION
WORK ADDRESS		STREET	CITY	STATE	ZIP	CELL PHONE	WORK PHONE OK TO CALL WORK <input type="checkbox"/> YES <input type="checkbox"/> NO
PERSON WE CAN CONTACT IN CASE OF AN EMERGENCY (OTHER THAN YOUR FAMILY HOME)							
NAME		RELATIONSHIP		HOME #	WORK #	CELL #	
OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE				WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE			
INSURANCE COVERAGE <input type="checkbox"/> YES <input type="checkbox"/> NO		INSURANCE COMPANY NAME			ADDRESS		PHONE
SUBSCRIBER'S NAME		PATIENT'S RELATIONSHIP TO SUBSCRIBER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT		SUBSCRIBER'S DATE OF BIRTH		SUBSCRIBER'S SSN	
GROUP/PROGRAM NUMBER		EMPLOYER (IF DIFFERENT FROM ABOVE)			EMPLOYER ADDRESS		
SECONDARY COVERAGE <input type="checkbox"/> YES <input type="checkbox"/> NO		INSURANCE COMPANY NAME			ADDRESS		PHONE
SUBSCRIBER'S NAME		PATIENT'S RELATIONSHIP TO SUBSCRIBER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT		SUBSCRIBER'S DATE OF BIRTH		SUBSCRIBER'S SSN	
GROUP/PROGRAM NUMBER		EMPLOYER (IF DIFFERENT FROM ABOVE)			EMPLOYER ADDRESS		

## ASSIGNMENT & RELEASE:

I hereby authorize my insurance benefits to be paid directly to the dentists. I am financially responsible for any balances due and authorize the dentists to release any information for this claim. I authorize that my records can be used by the doctor if he so determines.

In consideration of the services rendered to me by this dental office I am obligated to pay said office in accordance with its credit terms and policy.

I consent to the making of videotapes, photographs, and x-rays before, during, and after treatment, and to the use of same by the doctor in scientific papers or demonstrations.

I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

Signature \_\_\_\_\_ Date \_\_\_\_\_