Patient Name: ______________________________

Medical History:

Your current physical health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: ____

Name of physician: _______________________________________ Phone#: ___________________________

Date of last physical exam: ____

Do you need to be pre-medicated before dental treatment (history of heart murmur, bacterial endocarditis, mitral valve prolapse, etc., presence of metal plates, pins and rods in the body)? ☐ Yes ☐ No

Are you taking any prescription medications? ☐ Yes ☐ No If yes, please list below:

Name of medication: Purpose:

____

____

Do you smoke or use chewing tobacco? ☐ Yes ☐ No If yes, how much per day? _________________________

For Women:

Are you pregnant? ☐ Yes ☐ No If yes, how many months? _________ Are you nursing? ☐ Yes ☐ No
Are you taking birth control pills? ☐ Yes ☐ No
Do you plan on becoming pregnant in the near future and when? __________________________

Have you had any serious medical problems within the past 5 years? ☐ Yes ☐ No If yes, please explain:

____

Have you ever had, or been treated for any of the following diseases or medical problems?

Yes	No		Yes	No		Yes	No	
☐	☐	Heart Attack/Stroke	☐	☐	Heart murmur/Rheumatic fever	☐	☐	Heart Defects
☐	☐	Hepatitis/Jaundice	☐	☐	High/Low Blood Pressure	☐	☐	Pacemaker
☐	☐	Epilepsy/Seizures/Fainting	☐	☐	Abnormal Bleeding	☐	☐	Hemophilia
☐	☐	Cancer/Chemotherapy/Radiation	☐	☐	Kidney problems	☐	☐	Thyroid problems
☐	☐	Mitral Valve Prolapse	☐	☐	Psychiatric problems	☐	☐	Diabetes
☐	☐	Tuberculosis	☐	☐	Drug/Alcohol abuse	☐	☐	Liver Disease
☐	☐	Anemia	☐	☐	Arthritis	☐	☐	Venereal Disease
☐	☐	Artificial Bones/Joints/Valves	☐	☐	Asthma/Breathing problems	☐	☐	Emphysema
☐	☐	Blood Transfusion	☐	☐	Herpes/Fever Blister	☐	☐	Shingles
☐	☐	Colitis	☐	☐	Glaucoma	☐	☐	Sickle Cell Disease
☐	☐	HIV+/AIDS	☐	☐	Migraine Headaches	☐	☐	Sinus problem

Are you allergic to any of the following?

Yes	No		Yes	No		Yes	No	
☐	☐	Aspirin	☐	☐	Sulfa	☐	☐	Tetracycline
☐	☐	Codeine	☐	☐	Latex	☐	☐	Other: ___________
☐	☐	Dental Anesthetics	☐	☐	Penicillin			

Dental Questionnaire:

1. Why have you come to the dentist today? ____

2. These are the things that are important to me about my dental health: ____
____

3. Date of last dental visit: ______________________Previous dentist's name: ________________ Phone#: ____________________

4. Are you currently in pain or discomfort? ☐ Yes ☐ No
If yes, please explain: ____

5. Have you ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ No
If yes, please explain: ____

6. Does dental treatment make you nervous? ☐ No ☐ Somewhat ☐ Extremely

7. Have you ever been treated for periodontal disease (gum disease, pyorrhea, and trench mouth)? ☐ Yes ☐ No

8. Do you have any problems with bad breath? ☐ Yes ☐ No

9. Do your gums ever bleed when you brush? ☐ Yes ☐ No ...when you floss? ☐ Yes ☐ No

10. If you could easily and safely whiten your teeth, would you be interested? ☐ Yes ☐ No

11. Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

12. Do you grind or clench your teeth? ☐ Yes ☐ No

13. Do you snore loudly on most nights? ☐ Yes ☐ No

14. Has it ever been reported to you that you stop breathing or gasp during sleep? ☐ Yes ☐ No

15. Do you have any daytime sleepiness or fatigue? ☐ Yes ☐ No

16. Check One Box For Each Section:

A.
☐ My mouth is very comfortable.
☐ My mouth is moderately comfortable.
☐ My mouth is uncomfortable.

B.
☐ I think the appearance of my mouth is excellent.
☐ I am satisfied with the appearance of my mouth.
☐ I am dissatisfied with the appearance my mouth.

C.
☐ I will do anything to keep my natural teeth.
☐ I want to keep my teeth, but have a certain budget of time and money that I am willing to spend on them

D.
☐ I have always done the best that was recommended for my dental health.
☐ I have not done what dentists have recommended to me.
☐ I rarely go, and don't care much about having any dental work completed.

E.
☐ I have put dentistry for myself and family high on priority list.
☐ I put dentistry for myself and my family low on my priority list.
☐ Dentistry is on my list but it's hard to find.

F.
☐ I have set goals for my oral health with a previous dentist.
☐ I want to set goals concerning my dental health.
☐ I don’t care about setting goals for my oral health.

17. Insurance companies now allow for “functionally acceptable work,” whereas, in the past their coverage was for “quality work.” It is our desire to provide our patients with the highest quality work within their financial capabilities and desires. What is important to you? (Check one)

- ☐ The highest quality dentistry available.
- ☐ The most economical treatment plan.
- ☐ Dentistry limited to insurance coverage.
- ☐ A combination of the above. Please explain:

____

____

18. The following best describes my reason for seeking dental care (please check only one).

- ☐ Desire to avoid pain and prevent future problems.
- ☐ Desire to look my best and be more attractive.
- ☐ Desire to enjoy better health and feel good about myself.
- ☐ Desire to avoid problems early, save time, and to avoid preventable expenses in the future.
- ☐ Other____

19. Has anything kept you from receiving dental treatment in the past? ☐ Yes ☐ No

What was it? ____

20. What I expect from my dentist: ____

____

21. What are some questions about dentistry and oral health that you have never had adequately answered?

____

I understand that the information that I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. I assume the financial responsibility and obligation associated with the treatment I consented to.

Signature____ Date: ___________________________