Patient Information Cell phone -

Date _____

Full Name _____ Birth Date _____ Marital Status _____
Home Address _____ Zip _____ Home Phone _____
Occupation _____ Employer _____ Social Security No. _____
Business Address _____ Zip _____ Work Phone _____
Name of Spouse _____ Occupation _____ Employer _____
Dental Insurance Company _____ Policy No. _____
Referred By _____ Previous Dentist _____
Name of Physician _____ Phone No. _____
In Case of Emergency Contact _____ Phone No. _____

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

	Yes	No
1. Have you ever been hospitalized, major operations or serious illness? If so, what? _____	☐	☐
2. Are you under any medical treatment now?	☐	☐
3. Have you had any allergic reactions to any drugs including penicillin, codeine, novocaine, aspirin?	☐	☐
4. Has there been a change in your health in the past year?	☐	☐
5. Have you ever had a blood transfusion?	☐	☐
6. Have you ever had kidney dialysis treatment?	☐	☐
7. Have you ever had abnormal bleeding problems after a cut or tooth extraction?	☐	☐
8. Are you now taking drugs or medications? If so, what? _____	☐	☐

9. Has a physician ever informed you that you had:

	Yes	No		Yes	No
Heart Ailment	☐	☐	Hepatitis or Yellow Jaundice	☐	☐
High Blood Pressure	☐	☐	Liver Disease	☐	☐
Rheumatic Fever	☐	☐	Venereal Disease	☐	☐
Heart Murmur	☐	☐	AIDS	☐	☐
Mitral Valve Prolapse	☐	☐	Stomach or Intestinal Disease	☐	☐
Angina	☐	☐	Kidney Disease	☐	☐
Stroke	☐	☐	Tumors or Growths	☐	☐
Blood Disease	☐	☐	Diabetes	☐	☐
Hemophilia	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Respiratory Disease	☐	☐
			Epilepsy	☐	☐

10. Women: A. Are you pregnant? ☐ ☐
B. Estimated Date of Delivery _____

Medical History Summary

Blood Pressure:

Signature _____ Date _____

Updating _____

_____

_____

_____

_____

Dental History

	Yes	No
1. Please state briefly the reason for your visit. _____		
2. Do you have discomfort in your mouth now?	☐	☐
3. How long since your last dental visit? _____		
4. Were X-rays taken of all teeth at that time?	☐	☐
5. Do your gums bleed, feel tender or irritated?	☐	☐
6. Are your teeth sensitive to hot/cold/sweets?	☐	☐
7. Does food wedge between certain teeth?	☐	☐
8. Are any teeth loose?	☐	☐
9. Do you grind, clench or grit your teeth?	☐	☐
10. Does your jaw ever click or cause pain opening or closing?	☐	☐
11. Have your front teeth separated creating spaces in them recently?	☐	☐
12. Have you ever had any teeth extracted?	☐	☐
If yes, have they been replaced to prevent shifting and tipping of remaining teeth and bite collapse?	☐	☐
13. Did you ever wear braces?	☐	☐
14. Have you ever worn any dental appliances?	☐	☐
15. Have you ever had a root canal?	☐	☐
16. Have you ever had gum treatments?	☐	☐
17. Do you wear dentures or plates?	☐	☐
If yes, are you satisfied with your present dentures?	☐	☐
18. Have you experienced any growths or sore spots in your mouth?	☐	☐
19. Do you have an unpleasant taste in your mouth?	☐	☐
20. Do you floss your teeth?	☐	☐

21. Type of tooth brush _____ hard or soft (circle one)

Updating _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Dental History Summary

Clinical Examination

Date _____

Extraoral

Head _____
Skin _____
Eyes _____
Neck _____
Lips _____
Lymph Nodes _____

Intraoral

Mucosa _____
Frenuli _____
Palate _____
Floor of mouth _____
Tongue _____
Salivary glands _____
Tori _____

Gingiva

Architecture _____
Color _____
Tone _____
Suppuration _____
Hemorrhage _____
Recession _____
Calculus/plaque _____
Hypersensitivity _____
Mucogingival _____

Occlusion

Angle Class R _____ L _____
Overbite _____
Overjet _____
Crossbite areas _____
Wear facets _____
Diastemas _____
Fremitus _____
Cuspid protected _____
Group function _____
Anterior guidance _____
Premature contacts _____
Open contacts _____

Myofascial Pain Dysfunction

Clicking _____
Crepitus _____
Trismus _____
Muscle spasms (pain) _____
Headaches _____
Tinnitus _____
Subluxation _____

X-Rays

Alveolar Crest (type of bone loss) _____
Lamina dura _____
Perio space _____
Furcation _____
Retained roots _____
Maxillary sinus _____
Impactions _____
Calculus _____
Caries _____
Faulty restorations _____
Periapical & pulp pathology _____
Crown/root ratio (unfavorable) _____

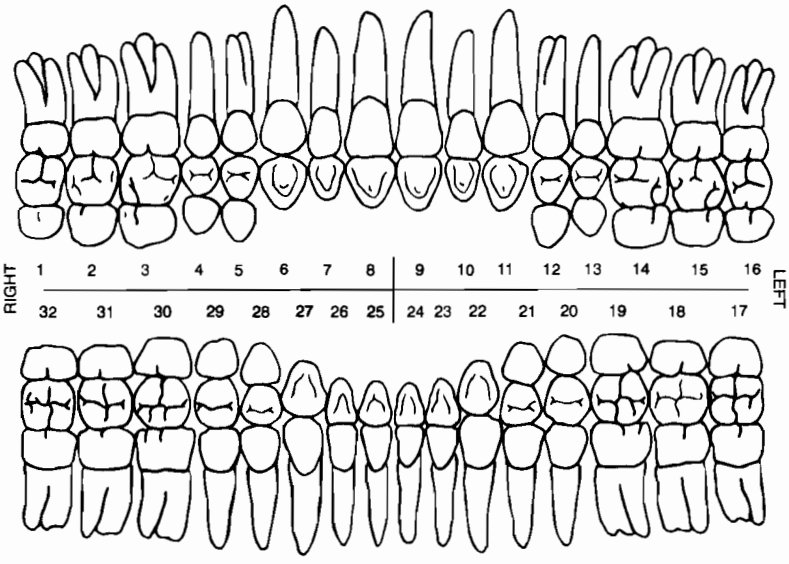
Updating _____

Clinical Examination Summary

Dental Examination

Date _____

		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Pocket Depth	B																
	L																
Mobility																	



Anesthetic Preferred

1. Headphones _____
2. Nitrous Oxide _____
3. Local Anesthesia _____
   Type _____

Medical Alert

		32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
Pocket Depth	B																
	L																
Mobility																	

Treatment Plan

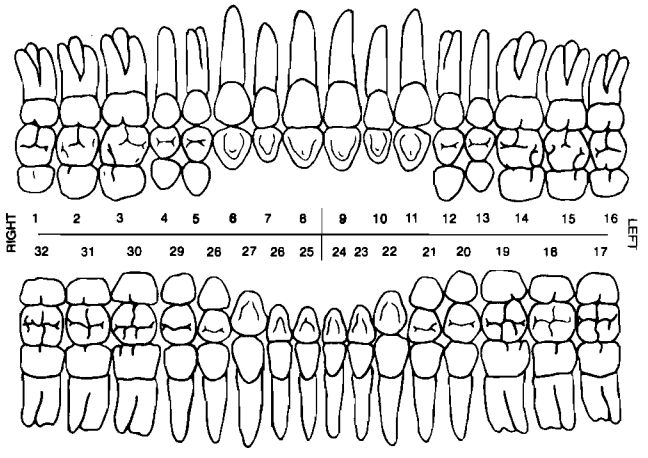
✔	Date	Tooth	Service Rendered	Seq.	Est.

✔	Date	Tooth	Service Rendered	Seq.	Est.

Subsequent Dental Examinations

Date _____

		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Pocket Depth	B																
	L																
Mobility																	



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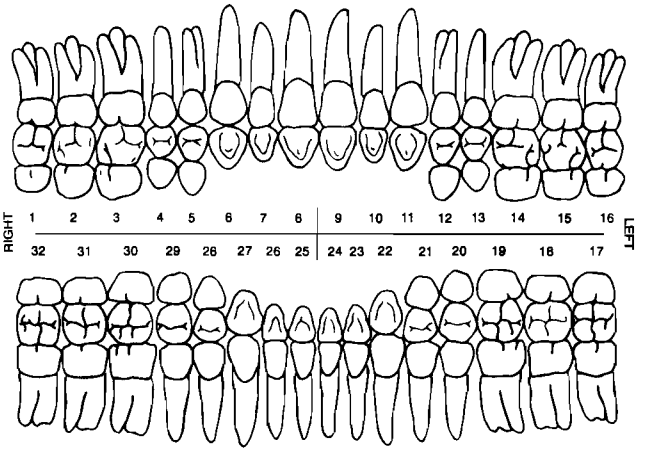
Pocket Depth	B																
	L																
Mobility																	

Remarks:

Hygiene:

Date _____

		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Pocket Depth	B																
	L																
Mobility																	



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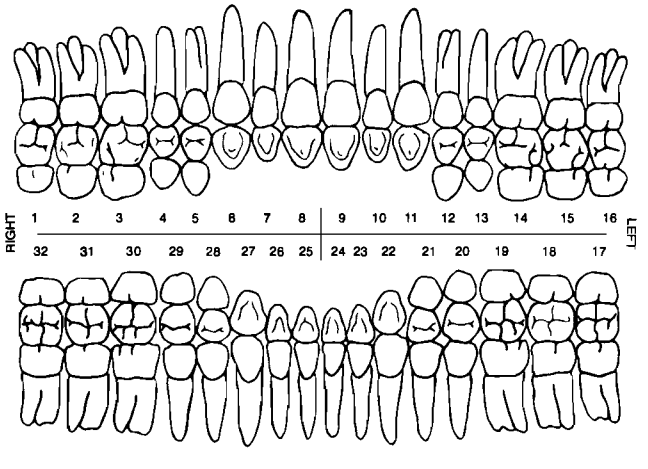
Pocket Depth	B																
	L																
Mobility																	

Remarks:

Hygiene:

Date _____

		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Pocket Depth	B																
	L																
Mobility																	



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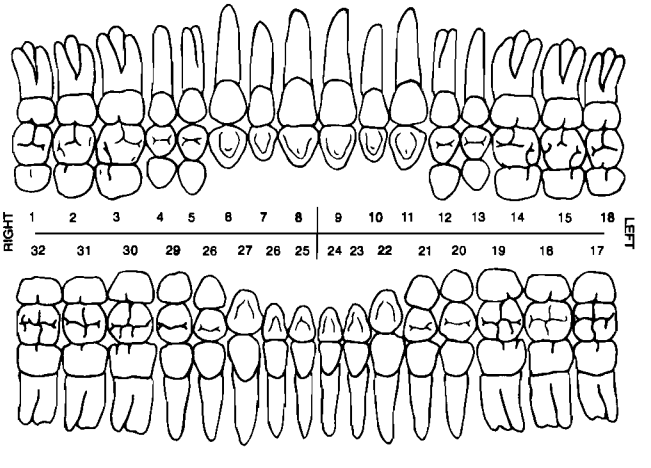
Pocket Depth	B																
	L																
Mobility																	

Remarks:

Hygiene:

Date _____

		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Pocket Depth	B																
	L																
Mobility																	



		32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
Pocket Depth	B																
	L																
Mobility																	

Remarks:

Hygiene:

Medical Alert ______________________

Date	Tooth	Services Rendered	Next Visit