DENTAL ARTS GROUP

First Name | Last Name | MI | Preferred Name

Gender: M F | Birthday | SSN

☐ Same address for entire family

Address | Address (cont)

City | State | Zip | Home Phone

Mobile | Email

Martial status

☐ Married ☐ Single ☐ Widowed ☐ Legally Separated

Name of Employer

Employment status

☐ Full Time ☐ Part-time ☐ Retired ☐ Not Employed Currently

Emergency Contact Name

Emergency Contact Phone

Emergency contact Relation

Patient Signature

Relationship to the patient (Self if patient)

Name if not patient

First Name:

Last Name:

- ☐ Allergies
- ☐ Amoxicillin allergy
- ☐ Anemia
- ☐ Anti-depressant meds
- ☐ Arthritis
- ☐ Asprin
- ☐ Asthma
- ☐ Augmentin Allergy
- ☐ Birth Control-taking
- ☐ Blood Disease
- ☐ Blood thinner taking
- ☐ By-pass surgery
- ☐ Cancer
- ☐ Cipro allergy
- ☐ Codeine Allergy
- ☐ Diabetes
- ☐ Dizziness
- ☐ Ear Trouble
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Erythromycin allergy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Hearing trouble
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Valve Replacement
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Impaired Vision
- ☐ Jaundice
- ☐ Joint Replacement
- ☐ Kidney Disease
- ☐ Latex allergies
- ☐ Liver disease
- ☐ Lupus
- ☐ Mental Disorders
- ☐ Metal allergy
- ☐ Mitral valve prolapse
- ☐ Nervous Disorders
- ☐ No Epinephrine
- ☐ Pace maker
- ☐ Panic attacks
- ☐ Penicillin Allergy
- ☐ Pregnancy
- ☐ Pre-med
- ☐ Radiation treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Take meds.-see list
- ☐ Ulcers
- ☐ Thyroid
- ☐ Zithromax allergy
- ☐ Tumors
- ☐ Venereal Disease

If any alerts of conditions that could benefit from further clarification, please describe below:

Are you allergic to any of the following?

- ☐ Penicillin
- ☐ Tetracycline
- ☐ Sulfa drugs
- ☐ Aspirin
- ☐ Codeine
- ☐ Latex
- ☐ Metals
- ☐ Dental Anesthetics

Other allergies not listed above:

Are you taking any medications at this time? Yes No

If yes, please list all Medications (prescribed and non-prescribed)

Have you been admitted to a hospital in the last two years? If yes, explain please:

Do you use tobacco?

Do you use alcoholic beverages?

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?

If yes, explain please

Women: Are you pregnant?

If yes, Due date:

Women: Do you take birth control medications?

Are you nursing?

To the best of my knowledge, all of the precedings answers and information provided are true and correct. If I ever have any changes in my health, I will inform the doctors at the next appointment without fail.

Patient Signature

Relationship to the patient (self if patient)

Name if not patent

Welcome to your new dental home. May we ask why you are changing dentist?

☐ Change of residence ☐ Change of dental plan ☐ Your office is closer ☐ My dentist retired/closed

☐ Unhappy ☐ Too expensive ☐ You're recommended ☐ Other

How long since you last visit to the dentist?

☐ 1 month ☐ 3 months ☐ 6 months ☐ 1 year

☐ 2 years ☐ 3 or more years ☐ I've never been to the dentist

How did you find us?

☐ Other patient ☐ Dental office ☐ Yelp ☐ Google

☐ Yellow Pages ☐ School ☐ Insurance Company ☐ Other

Who may we thank for referring you?

Reason for today's visit:

☐ Check-up ☐ Cleaning ☐ Pain ☐ Other

Any further information that could help us solve any of your dental concerns?

- Have you ever had an unfavorable reaction to dental anesthetic?
- Does dental treatment make you nervous?
- Are your teeth sensitive to cold, hot?
- Do your gums bleed when you brush or floss?

What type of toothbrush bristle do you use?

☐ Soft ☐ Medium ☐ Hard

What type of toothbrush?

☐ Electric ☐ Manual

Are you aware of sores or irritated areas in your mouth?

Please indicate any of the following problems by checking off the corresponding box(es):

☐ Discomfort, clicking or popping in jaw ☐ Lost / broken filling(s) ☐ Stained teeth

☐ Difficulty closing jaw ☐ Red, swollen or bleeding gums ☐ Teeth grinding / clenching

☐ Locking jaw ☐ Difficulty opening jaw ☐ A removable dental appliance

☐ Ringing in ears ☐ Bad breath ☐ Loose / shifting teeth

☐ Blisters/sore in or around mouth ☐ Broken / chipped tooth ☐ Burning tongue / lips

☐ Food caught between teeth ☐ Prolonged bleeding ☐ Toothache

☐ Swelling / lumps in mouth ☐ Recent infections ☐ Other

My teeth are sensitive to (Please check all that apply) :

☐ Hot ☐ Cold ☐ Sweets ☐ Biting

- Have you ever been treated for periodontal disease?
- Have you had braces (orthodontics) ?
- Have you had your wisdom teeth removed?
- How often do you brush?
- How often do you floss?
- How would you rate your smile (1 = I hate my smile / 10 = I love my smile)

If you had a magic wand. What , if anything would you change about your smile

☐ Change the color of my teeth ☐ Close spaces or restore worn and broken teeth

☐ Change the shape of my teeth ☐ Change the position or alignment of my teeth

☐ Other

We respect that everyone has difference goals for their teeth. Please circle your top two priorities for your mouth and teeth

1. I want to keep my teeth and do ONLY WHAT IS NECESSARY to keep them
2. I want to stop any current pain and avoid any sudden future pain
3. I want to be able to chew and function more comfortably
4. I want to improve my oral health and prevent bad breath
5. I want to treat any current and/or prevent any future infections
6. I want to improve the look of my smile

Please indicate any of the following problems by checking off the corresponding box(es):

☐ Teeth whitening ☐ Cosmetic evaluation ☐ Replacement of missing teeth

☐ Straight teeth ☐ Sedation ☐ Learning how to care for mouth

☐ Getting my mouth healthier ☐ Breath control ☐ Other / explain

Check all that apply (leaving blank indicates a NO)

☐ You snore or have been told by someone that you snore (2pts)

- ☐ You have been told that you quit breathing during your sleep (3pts)
- ☐ You awaken with a sensation of gasping or choking (3pts)
- ☐ You often feel tired or fatigued immediately after getting up from sleep (1pt)
- ☐ During your waking time, you often feel tired, fatigued, or not up to par (1pt)
- ☐ In the past 6 months you have nodded off or fallen asleep and you didn't intend to (1pt)
- ☐ You have (or being treated for) high blood pressure (1pt)

Total points [ ]

To ensure your visit is a great experience, please share any question or concerns you would like us to know about:

_____

_____

_____ _____

Signature Date

_____ _____

Name (if not patient)