

WE WELCOME NEW PATIENTS

(Ask about our Whitening Program / Care to Share program)



Patient Name: Last First Middle Initial Date of Birth: Male Female

Address: (mailing) Street City State Zip code

Address: (residence) Street City State Zip code Single Married

E-mail Address:

Telephone (home): Social Security #:

Telephone (work): Employer: Cell or Pager:

If Child, Parent's or Guardian's Name:

Name of Spouse:

Birth date: Employer:

Person Responsible for this account:

In case of emergency, Who should we notify?: Telephone:

How were you referred to our office?

Do you have Dental Insurance? yes no

Name of Insurance Company: Effective Date:

Subscriber Name: Social Security #: Birthdate:

Group of Policy#: Membership #: Dental Plan #:

Is there Secondary Dental Insurance? yes no

Name of Insurance Company: Effective Date:

Subscriber Name: Social Security #: Birthdate:

Group of Policy#: Membership #: Dental Plan #:

Health History: Name of Physician: Telephone:

Are Taking Any Medications? yes no If Yes, What?

Do You Have Any Allergies (or adverse reaction) to Any medications? no yes

Penicillin Sulfa Drugs Aspirin Epinephrine

Please Circle Any Of The Following That Apply:

- Heart Problem AIDS/HIV Lung Disease Artificial Joints Thyroid Disease
Rheumatic Fever Drug addiction Emphysema Abnormal Bleeding Mitral Valve Prolapse
High Blood Pressure Cancer Asthma Ulcers Pregnant
Arthritis Hepatitis A, B, or C Diabetes Fainting Other:
Heart Murmur Pacemaker Tuberculosis Epilepsy None Apply
Chemotherapy

Have you been taking Fosamax, Actonel, Zometa, Aredia or Pamidronate? yes no

Dental History: How long since your last dental appointment? How often do you have dental examinations?

Previous dental x-rays were taken: less than a year longer than a year

Have You Had Any Of The Following? (Please check if yes)

Have you experienced any of the following problem in your jaw?

- Do you experience pain (joint, ear, side of face) yes no
Do you have dizziness yes no
Ringing in the ear yes no
Ear congestion yes no
Do you have difficulty in opening or closing? yes no
Do you have difficulty chewing? yes no
Do you have frequent headaches? yes no
Have you had any head, neck, or jaw injuries? yes no
Does your jaw 'click' or hurt? yes no
Do you feel you grind or clench your teeth while awake or asleep? yes no
Have you ever had orthodontic treatment? yes no
Do you wear a dental night guard? yes no
Have you ever had periodontal (gum) treatment? yes no
Have you ever had your bite adjusted? yes no
Do you bite your lips or cheeks often? yes no
Do you smoke? yes no
Do you think you have occasional bad breath? yes no
Do your gums ever bleed when you clean your teeth? yes no
Do you snore or have been told that you do? yes no
Do you have daytime drowsiness? yes no
Have you been told that you stop breathing when sleeping? yes no
Do you feel un-refreshed in the morning? yes no
Do you have morning hoarseness? yes no

other notes:

Our office is like no other dental office. This will be the most important dental visit you will ever have. We place a high emphasis on helping you determine your present and future dental needs. Here are some things we are going to be talking about at your first visit. These are issues you have probably never thought of. Please check what best expresses how you feel about the following questions:

- Are you having any areas of concern? _____

- Tell us, in your opinion, what you think the present state of the health of your mouth is?

- What do you already know about our office and what are your expectations?

- How healthy do you want us to get your mouth?

“Don’t really care” Average “The best it can be”

- Should you need treatment, at what point should we address it?

When my tooth hurts or breaks When something is worsening When something isn’t ideal

- What quality of dentistry do you want us to recommend?

“Just patch it” Average Ideal/the best

- We have the ability to look at your mouth from 3 different perspectives. What combination of these would you like us to use for you? (please circle)

As a **general** dentist As a **cosmetic** dentist As a **functional** dentist

- How do you feel about the appearance of your face and smile? _____

- Tell us about your **good** dental experience: _____

And the **bad** ones: _____

- Has fear ever been an issue for you in a dental office? _____

- What caused you to leave your last dental office? _____

- Has time ever been a factor in getting your dental work done? _____

- Is there any additional information you would like us to know? _____

Patient Name: _____

Two areas that our office specializes in are Sleep Breathing Disorders and treating Temporomandibular Joint Disorder (TMJ). Please fill out the Epworth Sleepiness Scale below, and please check off any symptoms below that you currently have, which may be associated with TMJ. The doctor will go over all of this at the time of your consultation.

- No chance of dozing =0
- Slight chance of dozing =1
- Moderate chance of dozing =2
- High chance of dozing =3

Write down the number corresponding to your choice in the right hand column. Total your score below.

Situation	Chance of Dozing
Sitting and reading	
Watching TV	
Sitting inactive in a public place (e.g., a theater or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	

Total Score = _____

Temporomandibular Joint Disorder (TMJ) Symptoms (Please check all that apply)

- Headaches TMJ Pain TMJ Noise Limited Opening
 Ear Congestion Vertigo/Dizziness Ringing in Ears Difficulty Swallowing
 Loose Teeth Clenching/Bruxing Facial Pain Tender, Sensitive Teeth
 Cervical Pain Bells Palsy Nervousness/Insomnia Difficulty Chewing
 Paresthesia of Fingertips (Tingling) Hot & Cold Sensitivity Trigeminal Neuralgia