



Welcome to our practice! By filling out this form completely we can provide appropriate care with the right information.

PATIENT INFORMATION

Name _____ Nickname? _____
Last First Initial

Address _____ City _____

State _____ Zip _____ Home Phone _____ Cell phone _____

E-mail _____ Social Security # _____

Sex M F Age _____ Date of Birth _____ Single Married Widowed Separated Divorced

Employer _____ Occupation _____

Employer Address _____ Work Phone _____

Whom may we thank for referring you? _____

How did you hear about our office? Internet Search Our Website Facebook Twitter Coach's Newsletter

Notify in case of emergency _____ Home Phone _____ Cell Phone _____

Dental Insurance? Yes No Please provide dental insurance card.

DENTAL HISTORY

(circle one)

1. My mouth is: A.) very comfortable B.) moderately comfortable C.) uncomfortable
2. I (I am) : A.) think the appearance of my mouth is excellent B.) satisfied with the appearance of my mouth C.) dissatisfied with the appearance of my mouth
3. I : A.) will do anything to keep my natural teeth
B.) want to keep my teeth, but have a certain budget of time and money I am willing to spend on them
C.) don't care whether I keep my teeth or not
4. I : A.) have set goals for my dental health with a previous dentist B.) want to set goals for my dental health
C.) never set goals concerning my dental health
5. I : A.) have always done the best that was recommended for my dental health
B.) have not done what dentists have recommended for my mouth
C.) rarely go, and don't care much about having my dental work completed
6. I : A.) put dentistry for myself and my family high on my priority list
B.) put dentistry for myself and my family low on my priority list
C.) it's on my list but hard to find
7. I think my present state of dental health is: A.) excellent B.) good C.) poor
8. I aspire to a mouth with: A.) excellent health B.) good health C.) poor health



Previous Dentist _____ Date of most recent dental visit ____/____/____

I routinely see my dentist every: ____ 3 mo. ____ 4 mo. ____ 6 mo. ____ 12 mo. ____ Not routinely

What is your primary concern? _____

Please check **YES** or **NO** to the following:

YES **NO**

PERSONAL HISTORY

- 1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) (____) _____
- 2. Have you had an unfavorable dental experience? _____
- 3. Have you ever had complications from past dental treatment? _____
- 4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____
- 5. Did you ever have braces? _____
- 6. Have you had any teeth removed? _____

GUM AND BONE

- 7. Do your gums bleed or are they painful when brushing or flossing? _____
- 8. Have you been treated for gum disease or been told you have lost bone around your teeth? _____
- 9. Have you ever noticed an unpleasant taste or odor in your mouth? _____
- 10. Is there anyone with a history of gum disease in your family? _____
- 11. Have you ever experienced gum recession? _____
- 12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____
- 13. Have you experienced a burning sensation in your mouth? _____

TOOTH STRUCTURE

- 14. Have you had any cavities within the past 3 years? _____
- 15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____
- 16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____
- 17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____
- 18. Do you have grooves or notches on your teeth near the gum line? _____
- 19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____
- 20. Do you frequently get food caught between any teeth? _____

BITE AND JAW JOINT

- 21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____
- 22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? _____
- 23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____
- 24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____
- 25. Are your teeth crowding or developing spaces? _____
- 26. Do you have more than one bite and squeeze to make your teeth fit together? _____
- 27. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____
- 28. Do you clench your teeth in the daytime or make them sore? _____
- 29. Do you have any problems with sleep or wake up with an awareness of your teeth? _____
- 30. Do you wear or have you ever worn a bite appliance? _____
- 31. Do you wear a CPAP or snore appliance? _____
- 32. Have you ever had your bite adjusted? _____



YES NO

SMILE CHARACTERISTICS

- 33. Is there anything about the appearance of your teeth that you would like to change? _____
- 34. Have you ever whitened (bleached) your teeth? _____
- 35. Have you felt uncomfortable or self-conscious about the appearance of your teeth? _____
- 36. Have you been disappointed with the appearance of previous dental work? _____

MEDICAL HISTORY

Physician's name _____ Location _____

Date of last visit _____ Purpose of last visit _____

Women: Pregnant? Yes No Birth Control pills? Yes No Osteoporosis medication? Yes No

List all current medications: _____

List all allergies - medications, environmental, etc. _____

Please check **YES** or **NO** whether you have had any of the following:

- | | | |
|---|---|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N AIDS/HIV Positive | <input type="checkbox"/> Y <input type="checkbox"/> N Fainting | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral valve prolapse |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anaphylaxis | <input type="checkbox"/> Y <input type="checkbox"/> N Gastric reflux | <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N Headaches | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric care |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis | <input type="checkbox"/> Y <input type="checkbox"/> N Heart murmur | <input type="checkbox"/> Y <input type="checkbox"/> N Radiation treatment |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial heart valves | <input type="checkbox"/> Y <input type="checkbox"/> N Heart disease | <input type="checkbox"/> Y <input type="checkbox"/> N Respiratory disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial joints | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic/Scarlet fever |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Herpes | <input type="checkbox"/> Y <input type="checkbox"/> N Sleep apnea/snoring/CPAP |
| <input type="checkbox"/> Y <input type="checkbox"/> N Back problems | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis | <input type="checkbox"/> Y <input type="checkbox"/> N Shortness of breath |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer | <input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemical dependency | <input type="checkbox"/> Y <input type="checkbox"/> N Jaw Pain | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney disease | <input type="checkbox"/> Y <input type="checkbox"/> N Tobacco habit |
| <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N Latex allergy | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N Liver disease | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcer/colitis |

Additional notes: _____

I have completed these questions to the best of my knowledge and understand that this information will be used by Dr. Elliott to determine appropriate and safe dental care. I will inform this office of any change in my medical status. I authorize any insurance company to pay to Dr. Elliott all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I understand that I am responsible for all fees for services rendered whether or not paid for by insurance. I authorize the diagnosis of my dental health by means of radiographs, study models, digital photographs and any other diagnostic aids deemed appropriate. I also authorize the release of any diagnostic or treatment information to third-party insurance carriers/payors or other healthcare practitioners.

Signature of Patient, Parent or Guardian:

Signature: _____

Date: _____