

Optional Questions

1. Additional General Questions

Height

Weight

Do you have a family member that sees us?

2. Additional Dental Health Questions

How often do you have dental examinations?

How often do you brush your teeth?

How often do you floss?

What other dental aids do you use? (Interplak, toothpicks, etc)

Last dental exam?

Last dental cleaning?

Last dental x-rays?

Why did you leave your last dentist?

Do you feel like your mouth is clean and healthy?

Are you concerned about losing your teeth?

Have you lost any teeth? What caused the loss?

Have your parents had gum disease or tooth loss?

Have you noticed any mouth odors or bad tastes?

Does food get stuck in your teeth?

Do you have any difficulty swallowing?

Have you ever been given a drug, just before a dental visit, to prepare you for dental treatment? If Yes, what was the purpose?

Have you ever had excessive bleeding requiring special treatment?

Are there any sores or any growths in your mouth now?

Are your gums receding making your teeth look longer?

Have you been told you have gum problems?

Have you ever seen a periodontist (gum specialist)?

Do you have dentures or partial dentures?

Do you clench or grind your teeth while awake or asleep?

Do your jaws click?

Do you have pain in or around your ears?

Any difficulty opening or closing your mouth?

Any difficulty chewing?

Do you chew on only one side of your mouth?

Do you have swelling in your mouth?

Any bad taste in your mouth?

Do you bite your lips or cheeks regularly?

Do your jaws feel tired, especially in the morning?

Do you smoke or chew tobacco?

Have you ever had dental surgery?

Have you ever had braces?

Have you ever had a serious injury to the mouth or head? If so, please describe

Any sores or growths in your mouth?

Are you concerned about your dental insurance limitations?

Have you ever had instruction on proper oral care?

Have you had any head, neck or jaw injuries?

Have you ever experienced any of the following problems in your jaw? Clicking, pain, difficulty opening or closing, difficulty chewing

3. Additional Medical Health Questions

Have you been hospitalized within the past two years?

Have you taken any medication or drugs in the past two years?

Is your general health good? If No, please explain:

Has there been a change in your health within the last year? If yes, please explain:

Have you gone to the hospital or emergency room or had a serious illness in the last three years? If Yes, please explain:

Are you being treated by a physician now? If Yes, please explain

Date of last medical exam?

Reason for exam:

Besides any dental pain, do you have other pain right now? If yes, please explain:

Do you wear contact lenses?

Do you use tobacco?

Have you ever taken a drug called Fen-Phen?

Have you ever had:

Abnormal bleeding

Aids/HIV

Alcoholism

Allergies

Anemia

Angina

Any type of transplant

Any type of implant

Arthritis

Artificial heart valve

Artificial joint

Bisphosphonate treatment

Bleeding problems

Blood in stools

Blood transfusion

Blood in urine

Blurred vision

Bruise easily

Cancer

Canker or cold sores

Chemotherapy

Chest pains

Cold sores

Colitis

Congenital heart defect

Cosmetic surgery

Coughing up blood

Diarrhea or constipation

Difficulty urinating

Difficulty breathing

Difficulty swallowing

Dizzy spells

Drug addiction

Dry mouth

Easily winded

Eating disorders

Emphysema

Emphysema or other lung disease
Excessive thirst
Eye disease
Facial surgery
Family history of heart disease
Family history of diabetes
Fever
Fever blisters
Frequent headaches
Frequent vomiting
Frequent urination
Frequently tired
Hardening of arteries
Headaches
Heart surgery
Heart problems
Heart disease
Hemophilia
Hepatitis
Herpes
Jaundice
Joint replacement
Joint pain or stiffness
Joint replacement
Leukemia
Low blood pressure
Lung disease
Mental retardation
Mitral valve prolapse
Nervous disorder
Night sweats
Oral herpes
Osteoporosis
Pacemaker
Persistent cough
Radiation therapy
Recent significant weight loss
Recent weight loss
Respiratory problems
Rheumatic fever
Ringing in ears
Seizures
Sexually transmitted disease
Shingles
Shortness of breath
Sickle cell disease
Sinus problems
Skin disease
Sleep apnea
STD
Steroid treatment
Surgeries
Swollen ankles
Swollen ankles
Thyroid problem

Transplants
Tumors or cancer
Ulcers
Venereal disease

Are You Allergic to or Have You Had a Reaction to Any of the Following?

Aspirin
Codeine
Darvon
Demerol
Erythromycin
Latex
Local anesthetic (Novocain or Xylocaine)
Metal
Nitrous oxide
Penicillin
Percodan
Tetracycline
Valium
Vicodin
Others

Are You Taking or Have You Taken Any of the Following in the Last Three Months?

Alcohol
Antibiotics
Aspirin
Barbiturates
Codeine
Iodine
Over-the-counter medicines
Penicillin
Recreational drugs
Sulfa
Supplements
Tobacco in any form
Weight loss medications

Female Health Questions

Are you or could you be pregnant? If Yes, what month?

Are you breast feeding?

Are you taking any form of birth control?

Additional Statement Options

Not all services are covered by insurance. In the event your insurance plan determines a service to not be covered, you will be responsible for the complete charge. Our staff cannot guarantee your eligibility and coverage. Insurance rules and limits vary with insurance plans. If your insurance plan denies a service, you will be responsible for the charge. We do not base your treatment plan on what your insurance plan covers or does not cover.

The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my own health. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or healthcare practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

A \$25 fee will be charged for all appointment cancellations made without 24 hour notice.

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment. I therefore authorize the dentist to contact my physician.

Patient Signature: _____

Date: _____

Physician's Name: _____ Phone
number: _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

I hereby assign to _____ Dental any and all dental benefits otherwise payable to me for oral health treatment rendered by _____ Dental as described in the attached claim form. I acknowledge that I am still responsible for paying the above-referenced dentist to the extent the relevant insurer or payer does not pay the dentist in full.