PATIENT INFORMATION FORM

PART I: Personal Information

Last Name:_____ First Name:_____ Middle Initial:_____ Preferred Name:_____

Birth Date:_____ Marital Status:_____ Gender:_____

Ethnicity:_____ SS#:_____ DL#:_____

Address:_____ City:_____ State:_____ Zip:_____

Home #:_____ Work #:_____ Cell #:_____

☐ You have permission to email me ☐ You have permission to text me

Patient's or Parent's Employer Information:

Employer:_____ Occupation:_____

Address:_____ City/State/Zip:_____

Phone:_____

Emergency Information:

Person to contact in case of an emergency:_____ Phone:_____

PART II: Responsible Party Information

Name:_____ Relationship to Patient:_____

Birth Date:_____ SS#:_____ DL#:_____

Address:_____ City/State/Zip:_____

Phone #:_____ Work #:_____ Cell #:_____

PART III: Insurance Information - Primary Insurance

Insured Information:

Name:_____ Relationship to Patient:_____

Birth Date:_____ SS#:_____ DL#:_____

Employer:_____ Work #:_____

Address:_____ City/State/Zip:_____

Insurance Information:

Policy/ID#:_____ Group #:_____ Insurance Company:_____

Address:_____ City/State/Zip:_____ Union or Local #:_____

PART IV: Insurance Information - Secondary Insurance

Insured Information:

Name:_____ Relationship to Patient:_____

Birth Date:_____ SS#:_____ DL#:_____

Employer:_____ Work #:_____

Address:_____ City/State/Zip:_____

Insurance Information:

Policy/ID#:_____ Group #:_____ Insurance Company:_____

Address:_____ City/State/Zip:_____ Union or Local #:_____

PATIENT HEALTH HISTORY FORM

Why Do We Ask These Questions?

ANSWER: Because we are focused on wellness and helping you avoid unnecessary disease and higher health costs! Therefore, we ask health questions that might be new to you, at least for a dental office to be concerned about.

EXPLANATION: Our office believes in the current science - that mouth health and general health are connected; also that many health problems are preventable and avoidable. That's why we believe that proper identification of health risk factors and conditions can help us design an approach to your care that will improve your health through advanced preventive care, appropriate treatment strategies, and wellness coaching. We recognize that some questions about race, weight, gender and diet (among other particulars generally associated with medical visits) may at first seem unrelated to your dental visit. However, specific health issues such as cancer, heart disease, airway size/quality, and the risks for many disease conditions are connected to the mouth and can affect oral health and vice-versa.

Patient Name:_____ **DOB:**_____

PART I: Patient Concerns

Please check all that you are concerned about or currently have. If none apply, please check "None of the above."

Focus and Overall Objective
- ❑ Comprehensive evaluation
- ❑ Limited focus
- ❑ Keep my teeth is important
- ❑ None of the above

Jaw / Bite / Orthodontics
- ❑ Jaw joint noise or clicking
- ❑ Painful jaw, face or neck
- ❑ Headaches
- ❑ Ear pain
- ❑ Teeth wearing down
- ❑ None of the above

Teeth Cleanings & Gum Disease
- ❑ Bad breath
- ❑ Worried about gum disease
- ❑ Loose teeth
- ❑ Bleeding gums
- ❑ None of the above

Teeth and Fillings
- ❑ Broken fillings
- ❑ Broken teeth
- ❑ Sensitive teeth
- ❑ Toothache
- ❑ Dark fillings
- ❑ Tooth decay
- ❑ None of the above

Dentures and Implants
- ❑ Old dentures - don't like
- ❑ Existing dentures not secure
- ❑ Collapsed face
- ❑ Can't chew with dentures
- ❑ Interested in dental implants
- ❑ None of the above

Sleep Issues
- ❑ Hate CPAP - Intolerant
- ❑ Snoring or Sleep Apnea
- ❑ Excessive daytime tiredness
- ❑ None of the above

Cosmetics
- ❑ Do not like smile
- ❑ Have dark/stained teeth
- ❑ Want whiter smile
- ❑ Space/gaps between teeth
- ❑ Dark lines around crowns
- ❑ Crooked teeth
- ❑ None of the above

Biologic
- ❑ Mercury 'Amalgam' fillings
- ❑ None of the above

PART II: Patient Medications, Supplements & Surgeries

Please check all that apply. If none apply, please check "None of the above."

1. Do you take, have ever taken or have had any of the following:
- ❑ Breathing medications
- ❑ Antidepressants or sleeping pills
- ❑ Aspirin or blood thinners
- ❑ Dilantin or seizure medication
- ❑ Immunosuppressants
- ❑ Calcium channel blockers
- ❑ Heart valve surgery
- ❑ Joint or bone surgery
- ❑ None of the above

2. Do you have any of these allergies or reactions:
- ❑ Hay fever or sinus problems
- ❑ Latex (rubber) sensitivity
- ❑ Aspirin
- ❑ Penicillin or other antibiotics medicine
- ❑ Codeine or other pain
- ❑ Metals
- ❑ Medication
- ❑ None of the above

3. List any prescription medications, supplements, or surgeries you are taking or have had and the reason for it:

PART III: General Health

Please check all that apply. If none apply, please check "None of the above."

- ❑ In Good Health
- ❑ Health has changed in past year
- ❑ Under care of physician
- ❑ Increased age or assisted-living elder
- ❑ Serious illness or hospitalization in past 5 years
- ❑ Chronic ongoing or recurrent illness
- ❑ Pre-Meds/Antibiotics recommended prior to dental appointment
- ❑ None of the above

Do any of your family members have any of the following:

- ❑ Gum disease
- ❑ Dentures
- ❑ Diabetes
- ❑ Heart disease
- ❑ Cancer, Oral cancer
- ❑ Stroke
- ❑ Heart attack
- ❑ None of the above

Do you have any of the following disabilities:

- ❑ Physical
- ❑ Mental
- ❑ Learning
- ❑ Dexterity
- ❑ Disabilities interfere with health or hygiene
- ❑ None of the above

PART IV: Nutrition & Lifestyle

Please check all that apply. If none apply, please check "None of the above."

What is your diet rating:

- ❑ Good
- ❑ Fair
- ❑ Poor

- ❑ Eating disorders, Bulimia
- ❑ Take dietary supplements
- ❑ Drink carbonated/sweetened beverages
- ❑ Frequent snacking or eating
- ❑ Open to receiving information or help regarding nutrition

- ❑ Do NOT excercise regularly
- ❑ Lemon sucking
- ❑ Have gum, cough drops, or breath mints regularly
- ❑ High refined carbohydrate consumption
- ❑ None of the above

PART V: Vital Measurements

Please fill out the information below.

Weight:_____

Height: ____ **ft** ____ **in**

- ❑ Not satisfied with weight
- ❑ Abdominal obesity*

**Waist measurement of more than 40 inches in men, 35 inches in women.*

PART VI: Tobacco, Alcohol & Drugs

Please check all that apply. If none apply, please check "None of the above."

- ❑ Women: Two or more drinks per day average
- ❑ Men: Three or more drinks per day average
- ❑ Current smoker - Packs per day?_____ Interested in quitting?_____
- ❑ Former smoker - When did you quit? _____
- ❑ Chronic exposure to 2nd hand smoke
- ❑ Currently chewing tobacco - Cans per day?_____ Interested in quitting?_____
- ❑ Former chewer - When did you quit?_____
- ❑ Recreational drugs
- ❑ None of the above

PART VII: Medical Systems

Please check all that apply. If none apply, please check "None of the above."

Cardiovascular

- ❑ Heart murmur/damaged heart valve
- ❑ Heart stent or angioplasty
- ❑ Heart attack
- ❑ Stroke
- ❑ Angina, chest pain or discomfort
- ❑ Congestive heart failure
- ❑ Peripheral artery disease (PAD)
- ❑ Swollen ankles
- ❑ Bleeding/clotting problems
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Irregular or rapid heart beat
- ❑ Heart pacemaker
- ❑ None of the above

Endocrine Disorders

- ❑ Thyroid problems
- ❑ Pituitary or adrenal problems
- ❑ Insulin resistant / Pre-diabetes
- ❑ Diabetes - Type 1 (insulin dependent)
- ❑ Diabetes - Type 2 (diet and/or medication)
- ❑ Diabetes - Type 2 (insulin dependent)
- ❑ Diabetes is controlled
- ❑ None of the above

Cancer

- ❑ Cancer or tumor, oral cancer
- ❑ Chemotherapy or radiation therapy
- ❑ HPV positive (Human Papilloma)
- ❑ Sexual practices (multiple sex partners, oral sex, HPV positive sex partner)
- ❑ Excessive sun exposure
- ❑ None of the above

ENT - Head & Neck

- ❑ Headaches (migraine or tension)
- ❑ Jaw joint popping/clicking
- ❑ Limited mouth opening
- ❑ Jaw, face, neck or back pain
- ❑ Ear problems or pain
- ❑ Mouth breather
- ❑ Hay fever or sinus problems
- ❑ Snoring or Sleep Apnea
- ❑ Poor sleep
- ❑ Daytime tiredness
- ❑ Persistent sore throat/chronic cough
- ❑ Chronic hoarseness
- ❑ Unexplained numbness or pain
- ❑ Difficulty chewing
- ❑ Mouth sores 2+ weeks in duration
- ❑ Dentures with persistent sores
- ❑ Difficulty swallowing
- ❑ Difficulty moving jaw or tongue
- ❑ Lump, swelling in mouth or neck
- ❑ Numb mouth or tongue
- ❑ None of the above

Sleep

- ❑ Snoring
- ❑ Daytime tiredness
- ❑ Poor sleep
- ❑ Gasp air / stop breathing during sleep
- ❑ Large or thick neck
- ❑ Obstructive Sleep Apnea
- ❑ CPAP
- ❑ Oral sleep appliance
- ❑ Not currently using any therapy
- ❑ None of the above

Other Diseases & Conditions

- ❑ Liver disease or Hepatitis
- ❑ Tuberculosis
- ❑ AIDS / HIV positive
- ❑ Venereal Disease
- ❑ Chronic fatigue / Fibromyalgia
- ❑ Arthritis or Rheumatism
- ❑ Kidney disease
- ❑ Osteoporosis (bone loss)
- ❑ Acid Reflux / Heartburn (GERD)
- ❑ Frequent nausea / vomiting
- ❑ Gastrointestinal disease
- ❑ Ulcers, Colitis or Irritable bowel
- ❑ Lung disease
- ❑ Asthma
- ❑ Emphysema or COPD
- ❑ Epilepsy or Seizures
- ❑ Memory problems
- ❑ High stress or anxiety levels
- ❑ Dental phobia / Fear
- ❑ Depression
- ❑ Immune System Disorder
- ❑ Sjogren's syndrome
- ❑ None of the above

Gender Health

Female:

- ❑ Birth control pills
- ❑ Pregnant or planning pregnancy
- ❑ Nursing mother
- ❑ Menopause
- ❑ Hysterectomy

Male:

- ❑ Erectile dysfunction
- ❑ None of the above

PART VIII: Dental

Please check all that apply. If none apply, please check "None of the above."

- ❑ Longer than 2 years since last dental cleaning
- ❑ Brush less than 2x/day
- ❑ No daily floss / Oral irrigation
- ❑ Irregular or episodic professional care
- ❑ Complications after dental treatment
- ❑ Tooth sensitivity
- ❑ Teeth grinding
- ❑ Dry mouth
- ❑ Worn, broken, cracked teeth or fillings
- ❑ New tooth decay/cavities in last 3 years
- ❑ Orthodontic braces
- ❑ Dentures
- ❑ Wisdom teeth removed
- ❑ Bleeding gums
- ❑ Past or present gum disease or surgery
- ❑ Deep cleanings in past
- ❑ Receding gums
- ❑ Loose teeth
- ❑ Unhappy with smile
- ❑ Poor family dental health
- ❑ None of the above