In an effort to better care for you as well as provide insight as to your past dental and healthcare please provide the following information to the best of your ability. You may elect to obtain records from your previous treating clinicians.

Demographic data	
Title (Ex: Mr., Mrs., etc.)	
Name	
Marital status	
Date of birth	
Sex	
Education (High school, Grad, Postgrad)	
Occupation	
Home address	
Telephone numbers	
Patient's E-mail:	
Referral Source	
Clinical Examination scheduled:	

Childhood Dental History

As a child the I was treated by a dentist - Check one:

On a regular basis for prevention	
As needed for emergencies	
Infrequently evaluated by the dentist	
Never seen by a dentist	

During the time of my School years, I was treated by the following dentists

Dentist Name _____ Date of Care ___/___/____.

Dentist Name _____ Date of Care ___/___/____.

Dentist Name _____ Date of Care ___/___/____.

Dentist Name _____ Date of Care ___/___/____.

Adult Dental Surgeries and Restoration

Please note any major problems you have had pertaining to your teeth. (For example: Cracked teeth, Root canals, Extractions, etc.) and the nature of treatment. If possible, include the approximate time and clinician providing the service

Dental Problem	Dental Procedure	Date of Treatment	Clinician Providing Treatment
		/ /	
		/ /	
		/ /	
		/ /	

Please note any implants or missing teeth you currently have in your mouth and the Dentist who did the Extraction or the Implant. If you know the tooth number, please list it if not, describe the region of mouth (For example: upper front, lower left, etc.). Include Date of extraction and Type and date of Implant.

Tooth Lost/Region	Date of Tooth Loss	Reason for Etraction	Clinician Providing Treatment
	/ /		
	/ /		
	/ /		
	/ /		

Dental Implants previously Inserted	Region of mouth	Type of Implant	Clinician inserting implant	Date of insertion	Clinician restoring Implant	Date of restoration
				/ /		/ /
				/ /		/ /
				/ /		/ /
				/ /		/ /

Orthodontic History

I had orthodontic treatment from ages ____ to ____ or (circle) never.

Name of Orthodontist _____.

Did you have any teeth extracted as part of ortho treatment?

_____

_____

Sleep Issues

	Yes	No
Do You wake up Tired?		
Do You feel tired during the day?		
Are You aware of snoring?		
Have you been told that you have sleep apnea?		
Have you ever had a sleep study?		

Sleeping Position

Please note your regular sleeping position with details including the type pillow and mattress you may use, how long it takes you to fall asleep, the duration of your sleep, and if you snore.

_____

_____

_____

_____

Diet/Nutrition & Lifestyle Management

My current height is___'___ tall and I weigh _____ lbs. I waver between the weights ____lbs. to ____lbs.

I use tabaco (check one).

Regularly	
Sometimes	
Infrequently	
Never	

Please add any information you can on this topic. _____

_____

_____

Alcohol Consumption (check one).

Regularly	
Sometimes	
Infrequently	
Never	

Please add any information you can on this topic. _____

_____

_____

I smoke other substances (check one).

Regularly	
Sometimes	
Infrequently	
Never	

Please add any information you can on this topic. _____

_____

_____

Occlusal (Bite) Problems

	Yes	No
I am aware of grinding or clenching my teeth		

I use a nightguard (yes, no). If yes, how often do you experience pain in your teeth/gums?

_____

_____

Pain

I am currently Experiencing Pain associated with

_____

_____

Do you believe stress plays a material role in your pain or sleep patterns? If so please explain.

_____

_____

Do you experience regular pain from multiple teeth at different times.? If so, explain.

_____

_____

Have you found anything in particular to help your pain? (example: vitamin supplements, massages, acupuncture, pain medication etc.)

_____

_____

In what ways does your pain present itself? (example: sharp pain, soreness/numbness, and/or sensitivity to touch, etc.)

_____

_____

Are your teeth sensitive to hot/cold temperatures? If so, please explain what kind of pain it inflicts and what area it affects.

_____

_____

Loose Teeth

Are any of your teeth loose?

_____

_____

Before losing any teeth what signs did you notice? (for example: looseness of a tooth, painful muscles around the tooth, etc.)

_____

_____

Significant medical issues

I have the following known allergies:

_____

_____

_____

_____

I am taking the following medications:

Medicine	Dosage	Reason for taking Medication
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you been diagnosed with any of the following conditions?

	Yes	No
Diabetes		
Clotting disorders		
Cardiac issues		
Autoimmune issues		
Hyper cholesteremia		
Depression		
Gastroesophageal reflux disease		

Have you had any complications during or after a dental procedure? If so, please explain.

_____

_____

The name of my primary care physician is _____.

The phone number for my primary care physician is _____.