PATIENT INFORMATION AND HEALTH HISTORY

INITIAL EXAM

DATE ____________

PATIENT'S NAME ____________ DATE OF BIRTH ____________

PERSONAL RESPONSIBLE FOR THIS ACCOUNT ____________ RESIDENCE PHONE ____________

____

EMPLOYED BY ____________ BUSINESS PHONE ____________

DENTAL INSURANCE PLAN (IF ANY) ____________

DENTAL HISTORY

CHIEF ORAL CONCERN ____________

DATE OF LAST DENTAL EXAM ____________ ANY PREVIOUS MAJOR DENTAL TREATMENT: ☐ YES ☐ NO WHEN ____________

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING? INDICATE WITH A (✔)

- ☐ Sensitive teeth
  - ☐ Cold
  - ☐ Hot
  - ☐ Sweets
  - ☐ Pressure
- ☐ Discolored or stained teeth
- ☐ Chipped or worn teeth
- ☐ Missing teeth
- ☐ Spaces between teeth
- ☐ Rotated teeth
- ☐ Other ____________

- ☐ Clenching or grinding
- ☐ Pain around ear
- ☐ Unusual sounds in ear while eating
- ☐ Bleeding gums, How long ____________
- ☐ Food impaction
- ☐ Bad breath
- ☐ Unpleasant taste
- ☐ Mouth breathing
- ☐ Oral habits, i.e., fingernail biting, cheek biting, etc.
- ☐ Burning of tongue
- ☐ Swelling or lumps in mouth
- ☐ Frequent blisters on lips or mouth

- ☐ Unfavorable dental experience ____________
- ☐ Complications from extractions
- ☐ Periodontal treatment
- ☐ Orthodontic treatment
- ☐ Texture of toothbrush ____________
- ☐ Frequency of brushing ____________
- ☐ Frequency of flossing ____________
- ☐ Oral care appliances, i.e., Interplak, Braun, Sonicare, Water Pik
- ☐ Fluoride supplements

TOBACCO USE ASSESSMENT

1. Do you use tobacco in any form? ☐ yes ☐ no

1A. If no, have you ever used tobacco in the past? ☐ yes ☐ no

How long did you use tobacco? years_____ months _____

How long ago did you stop? years_____ months _____

If you are not currently a tobacco user, no other questions should be answered.

Questions 2 to 10 are for current tobacco users only.

2. If you smoke, what type? (check) How many? (number)

Cigarettes ________ cigarettes per day ________

Cigars ________ cigars per day ________

Pipe ________ bowls per day ________

2. If you chew/use snuff, what type? How much?

Snuff ________ days a can lasts ________

Chewing ________ pouches per week ________

Other (describe)____________ amount _____ per _____

3A. How long do you keep a chew in your mouth? minutes _____

4. How many days of the week do you use tobacco? 7 6 5 4 3 2 1

5. How soon after you wake up do you first use tobacco?
☐ within thirty minutes ☐ more than 30 minutes

6. Does the person closest to you use tobacco? ☐ yes ☐ no

7. How interested are you in stopping your use of tobacco?
☐ not at all ☐ a little ☐ somewhat ☐ yes ☐ very much

8. Have you tried to stop using tobacco before? ☐ yes ☐ no

8A. How long ago was your last try to stop? years_____ months_____

9. Have you discussed stopping with your physician? ☐ yes ☐ no

10. If you decided to stop using tobacco completely during the next two weeks, how confident are you that you would succeed?
☐ not at all ☐ a little ☐ somewhat ☐ yes ☐ very confident

APPOINTMENTS: A minimum charge will be made for a failed or cancelled appointment without prior notification of 24 hours. This fee covers only a portion of the overhead which has to be paid whether you are present or not. Once an appointment is made, please remember this time has been reserved for you.

INSURANCE: To avoid misunderstanding regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient. You are personally responsible for payment of fees. We will prepare the necessary forms or reports to help you obtain your benefits from insurance companies upon receipt of full (or partial) payment of the bill. We do not render our services on the basis that insurance companies will pay all our fees. Each fee is individual for the individual patient.

SIGNATURE ____________ DATE ____________
(PARENT OR GUARDIAN, IF PATIENT IS A MINOR)

PATIENT'S NAME ____________