New Patient Intake & Health History

Patient General Information

Full Name (First, Last): ______________________________ DOB: ________________________

Sex: (M/F) Martial Status: (Single/Married/Divorced/Widowed)

Address: ____

City:____________________________ State: __________________ Zip code: ________________

Contact Information:

Home phone: ___________________ Work: __________________ Cell: ___________________

Email: ____

Emergency Contact:

Name: ________________________ Relationship: _________________________

Phone Number:____

Previous Dentist:

Name: ______________________________ Phone Number:______________________

Email:_______________________________ Date of Last Visit:_____________________

Medical Physician:

Name: ______________________________ Phone Number:______________________

Email: ______________________________ Date of Last Visit: ____________________

If Minor:
Parent/Guardian:______________________
Address:____
Phone Number:________________________

Dental History

Chief Complaint(s): ____

____

Treatment Concerns:
Any previous bad dental experiences? (YES/NO)
Any need for anxiety control for dental appointments? (YES/NO)
Any physical constraints- gag reflex/issues swallowing? (YES/NO)

Oral Hygiene:
Do you floss daily? _______________ If not, how often do you floss? ________________________
Do you use an (ELECTRIC TOOTHBRUSH/MANUAL TOOTHBRUSH)
Do you use mouth rinses? (YES/NO) Do they contain alcohol (YES/NO)
Do you have regular hygiene/cleaning appointments? (YES/NO)

Metals:
Do you currently have amalgam fillings? (YES/NO)
If yes, do you want them removed? (YES/NO)
Have you previously had amalgam fillings removed? (YES/NO) Was it done safely? (YES/NO)
Do you have any bluish/black spots on your gums? (YES/NO)
Do you have any metal crowns or PFM? (YES/NO)
Do you have any titanium implants? (YES/NO)

Orthodontics (Braces):
Did you ever have braces? (YES/NO). If so, approximately at what age? _________________
Did you ever have Invisalign? (YES/NO) If so, approximately at what age? __________________
Do you currently have permanent metal retainers? (YES/NO)

Chronic Infections:
Do you have any root canal treated teeth? (YES/NO)
Any symptoms/issues currently? (YES/NO) Please describe: ____________________
Any teeth extractions (including wisdom)? (YES/NO)
Any symptoms/issues currently? (YES/NO) Please describe: ____________________
Periodontal disease or infection? (YES/NO)
Had scaling/root planning or gum surgery? (YES/NO)

Have you taken Fosamax, Bonita, or any other Bisphosphonate drug in the past? _________

Have you had any radiation therapy?__________ Where?________________________

Dental History (check all that apply):

Mouth/Teeth

___ Abnormal opening
___ Limited opening
___ Bad bite/ Malocclusion
___ Missing teeth
___ Clenching/grinding
___ Inability to find bite
___ Sour/foul taste
___ Mouth discomfort
___ Burning tongue
___ Dry mouth
___ Tooth pain
___ Implants (titanium or zirconia)
___ Root canals (how many? _______)
___ Prone to cavities
___ Gingivitis
___ Bleeding gums
___ TMJ pain
___ Clicking of Jaw

Head, Neck, & Dental History (check all that apply):

Head/face

___ Forehead headaches
___ Temporal headaches
___ Tension headaches
___ Migraine-type headaches
___ Sinus headaches
___ Back of head headaches
___ Scalp tender to touch

Neck

___ Lack of mobility
___ Stiffness
___ Neck pain
___ Tired/sore neck muscles
___ Shoulder pain
___ Back pain
___ Arm/finger pain or numbness

Jaw

___ Jaw pain
___ Jaw joint pain
___ Clicking/popping in jaw joint(s)
___ Grinding sound in jaw joints(s)
___ Pain in cheek muscles
___ Uncontrollable jaw movements
___ Jaw locks open/shut
___ Deviation of jaw to one side

Ears

___ Ear pain without infection
___ Decreased hearing
___ Clogged/stuffy feeling in ear(s)
___ Itchy feeling in ear(s)
___ Ringing/buzzing in ear(s)
___ Dizziness
___ Balance problems

Eyes

___ Pain in/around eyes
___ Bloodshot eyes
___ Sensitivity to light
___ Tearing of eyes
___ Blurred vision
___ Pressure behind eyes
___ Dark circles under eyes

Throat

___ Difficulty swallowing
___ Feeling of foreign object in throat
___ Sore throat without infection
___ Voice changes
___ Laryngitis
___ Frequent coughing

Nasal

___ Sinus pain
___ Sinus problems
___ Post-nasal drainage
___ Allergies

Sleep

___ Snoring
___Sleep apnea
___ Have been told I snore
___ Have been told I stop breathing
___ Have awoken gasping for breath

Medical History (check all that apply):

Anemia	Diverticulosis	Liver/Hepatitis	Prostate Disorder
Anxiety	DVT/Blood Clots	Lyme Disease	Psychiatric
Arthritis	Epilepsy	Menstrual Disorder	Seizure Disorder
Asthma	Heart Attack/Failure	Migraines	Sleep Apnea
Autoimmunity	Heart Disease	Neurological	Stroke
Bleeding Disorder	High Blood Pressure	Neuropathy	Thyroid Disorder
Cancer	High Cholesterol	Osteoporosis	Vascular Issue
Diabetes	Kidney Disease	POTS	Kidney Disease

Other:

If you have any of the above, please include date of onset and management:

Surgeries (include year of surgery):

Medications (please list prescribed and over the counter medications):

Prescription Name:	**Dosage:**	**Reason:**

Supplements/Vitamins (please list all current supplements & vitamins)

Supplement/Vitamin:	Dosage:	Reason:

Allergies & Reactions to Medications (please Circle or write in):

Allergy:	Reaction/Comment:
Penicillin Allergy (YES/NO)	
Pain killers (Codeine/ Asprin/ Other)	
Other Drugs (Local anesthetics/ Barbituates)	

Food/Environmental Allergies & Reactions (please Circle or write in):

Food/Environmental Substance	Reaction/Comment:
(Shellfish/Iodine/Nuts/Grains/Dairy)	
(Metals/Plastics/Ceramic/Latex)	

Personal Health Habits:

Alcohol Consumption:	Never	Occasionally	Weekly	Daily
Cigarette/Tobacco Use:	Never	Occasionally	Weekly	Daily
Recreational Drug Use:	Never	Occasionally	Weekly	Daily
Sugar Consumption:	Never	Occasionally	Weekly	Daily
Caffeine Consumption:	Never	Occasionally	Weekly	Daily

Family Medical History:

Family Member	Age, Age at Death	Medical Conditions

I have read all information and completed the above answers.
I certify this information is true and correct to the best of my knowledge. I will notify this office of any changes in the above information.

Patient Name (printed): ____

Patient Signature: ____________________________________ **Date**: _________________

Parent/Guardian Signature:_____________________________ Date:_________________

Parent/Guardian Signature:_____________________________ Date:_________________