

Dental Information

How may we help you? (chief concern)

Are you sensitive to:

hot? Yes No

cold? Yes No

sweet? Yes No

biting pressure? Yes No

Do you favor chewing one side? Yes No

If yes, which side? _____

Do you have any areas that catch food? Yes No

If yes, which area? _____

Do your gums swell? Yes No

Are they irritated, tender or swollen? Yes No

Do your gums bleed when brushing? Yes No

Do you think or have you ever been told you have

bad breath (halitosis)? Yes No

Do you avoid any part of your mouth while eating,

chewing, or brushing? Yes No

Do you have any missing teeth? Yes No

If so, have they been replaced? Yes No

When was the last time you had a complete

dental examination, including x-rays?

Have you had your teeth cleaned regularly? Yes No

How often? _____

How often do you floss your teeth?

How often do you brush your teeth?

How do you feel about your smile?

How do you feel about your teeth in general?

What would you change about your teeth/smile?

Have you had any previous injuries to the face or jaws?

Yes No

Do you have frequent headaches or earaches?

Yes No

Have you noticed excessive wear to your teeth?

Yes No

Are you aware of clenching or grinding your

teeth, especially at night? Yes No

Do any teeth feel loose? Yes No

Do you feel comfortable about having dental treatment?

Yes No

How did you decide to choose our office for your

dental care?

Who may we thank for referring you to our office?

Medical Information

Do you have any general health problems? Yes No

If so, please specify:

Have you been a patient in the hospital during the past 2 years? Yes No

Have you been under the care of a medical doctor during the past 2 years? Yes No

What medicine or drugs are you now taking?

If you are taking several medicines, please bring your list with you at each visit.

Are you currently under a physician's care? Yes No

Are you allergic to (i.e., itching, rash, swelling of hands, feet, eyes) penicillin, aspirin, codeine, or any other drugs or medications? Yes No

If yes: _____

Have you ever had excessive bleeding requiring special treatment? Yes No

Circle any of the following which you have had or have at present:

Heart Failure

Heart Disease or Attack

Anemia

Angina Pectoris

Artificial Joint

Artificial Heart Valve

Congenital Heart Lesions

Heart Murmur

Heart Pacemaker

Heart Surgery

Blood Pressure High/Low

Kidney Trouble

Rheumatic Fever

Scarlet Fever

Stroke

Ulcers

Asthma

Cough

Emphysema

Tuberculosis (TB)

Liver Disease

Allergies or Hives

Diabetes

Hay Fever

Sinus Trouble

Thyroid Disease

Arthritis

Colitis

AIDS

Blood Transfusion

Cancer or Tumor

Chemotherapy

(Cancer, Leukemia)

Cobalt Treatment

Cortisone Medicine

Drug Addiction

Epilepsy or Seizures

Fainting or Dizzy Spells

Genital Herpes

Glaucoma

Hemophilia

Hepatitis A (infection)

Hepatitis B (infection)

Nervousness

Pain in Jaw Joints

Psychiatric Treatment

Rheumatism

Sickle Cell Disease

Venereal Disease

(Syphilis, Gonorrhea)

Yellow Jaundice

Cold Sores

Hearing Disabilities

Bruise Easily

Abnormal Bleeding

We'd like to get to know you better!

FULL NAME _____

ADDRESS _____

HOME PHONE _____

CELL PHONE _____

WORK PHONE _____

EMAIL ADDRESS _____

OCCUPATION _____

EMPLOYER _____

EMPLOYER ADDRESS _____

DATE OF BIRTH ___/___/___ MALE FEMALE

WEIGHT _____ HEIGHT _____

SOCIAL SECURITY NUMBER _____-_____-_____

MARITAL STATUS _____

SPOUSE'S NAME _____

DATE OF BIRTH _____

OCCUPATION _____

PERSON RESPONSIBLE FOR PAYMENT _____

WHAT DENTAL INSURANCE? _____

PLAN OR GROUP # _____

WHOSE NAME IS THE INSURANCE COVERAGE UNDER? _____

SOCIAL SECURITY NUMBER _____-_____-_____

EMPLOYER NAME/ADDRESS _____

Because we diagnose and treat sleep disorders, please answer the following questions:

Do you experience frequent, heavy snoring? Yes No

Do you experience significant daytime drowsiness? Yes No

Have you been told you stop breathing while sleeping? Yes No

Do you gasp at times when waking up? Yes No

Do you feel unrefreshed in the morning? Yes No

Do you have morning headaches? Yes No

Are you aware of any teeth grinding at night? Yes No

Do you often experience nasal congestion? Yes No

Do you wear a CPAP? Yes No

If so, when did you start wearing it? _____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health, or if my medicines change, I will inform the doctor of dentistry at the next appointment without fail.

Date _____

Patient Signature (or Parent if Patient is under 18)

Thank you for filling out our Medical and Dental History so thoroughly.

Voller Dentistry

When you walk up stairs or take a walk, do you ever stop because of pain in your chest or shortness of breath, or because you are very tired? Yes No

Do your ankles swell during the day? Yes No

Have you (circle one) lost or gained more than 10 pounds in the past year? Yes No

Do you ever wake up from sleep short of breath? Yes No

Are you on a special diet? Yes No

Do you use tobacco? Yes No

What _____ Quantity _____

Are there any other medical conditions or problems not previously listed that may reflect your dental treatment? Yes No

Are you pregnant now? Yes No

Approximate date of last medical examination _____

Nearest relative not living with you _____

_____ Phone _____

Person to contact in case of an emergency _____

_____ Phone _____

I give my consent to have any study models and photographs of my face and mouth to be used for educational or promotional purposes.

Date _____

Patient Signature (or Parent if Patient is under 18)
