**Welcome to Voller Dentistry. We'd like to get to know you better so that we can do our best to ensure your total oral health!**

## ABOUT YOU

| | |
|---|---|
| Full Name: | |
| Address: | |
| Home Phone: | |
| Cell Phone: | |
| Work Phone: | |
| Email: | |
| Occupation: | |
| Employer: | |
| Employer Address: | |
| Date of Birth: | ______/______/______ |
| Height: | |
| Gender | ◻ Male ◻ Female |
| Weight: | |
| Social Security Number: | ________-______-________ |
| Marital Status: | |
| Spouse's Name: | |
| Spouse's Occupation: | |
| Person Responsible for Payment: | |
| What dental insurance? | |
| Plan or Group #: | |
| **Primary Insurance Holder**<br>Name:<br>Date of Birth:<br>Social Security Number:<br>Employer's name and address: | ____________________<br>______/______/______<br>________-______-_____<br><br>_________________________ |

## DENTAL INFORMATION

| | |
|---|---|
| How may we help you? What's your chief concern? | |
| Are you sensitive to… | Hot? ◻ Yes ◻ No<br>Cold? ◻ Yes ◻ No<br>Sweet? ◻ Yes ◻ No<br>Biting pressure? ◻ Yes ◻ No |
| Do you favor chewing on one side? | ◻ Yes ◻ No<br>If yes, which side? _______________ |

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|---|---|
| Do you have any areas that catch food? | ☐ Yes ☐ No<br>If yes, which area? ____________ |
| Do your gums swell? | ☐ Yes ☐ No |
| Are your gums 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<br>If so, have they been replaced?<br>☐ Yes ☐ No |
| When was the last time you a complete dental examination, including x-rays? | |
| Have you had your teeth cleaned regularly? | ☐ Yes ☐ No<br>How often?____________ |
| How often do you floss your teeth? | |
| How often do you brush your teeth? | |

| | |
|---|---|
| How do you feel about your teeth in general? | |
| What would you change about your teeth/smile? | ☐ Straighter<br>☐ Whiter<br>☐ Better shape<br>☐ Gum health<br>☐ Other____________ |
| 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 or who may we thank? | |

# MEDICAL INFORMATION

| | |
|---|---|
| Physician(s) seen most often and/or primary care doctor. | Name:__________<br>Phone:__________<br>Name:__________<br>Phone:__________ |
| Have you been ill, hospitalized or treated for anything in the past two years? | □ Yes □ No<br>If yes, please explain: |
| What medication or drugs are you now taking? [If you are taking several medicines, please bring your list with you at each visit. | |
| Are you allergic to penicillin, aspirin, codeine, or any other drugs or medications? (e.g. itching rash, swelling of hands, feet, or eyes) | □ Yes □ No<br>If yes, list drugs and reactions: |
| 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 | Stroke | AIDS |
| Heart Disease or Attack | Ulcers | Blood Transfusion |
| Anemia | Asthma | Cancer or Tumor |
| Angina Pectoris | Cough | Chemotherapy (Cancer, |
| Artificial Joint | Emphysema | Leukemia) |
| Artificial Heart Valve | Tuberculosis (TB) | Cortisone Medicine |
| Congenital Heart | Liver Disease | Drug Addiction |
| Lesions | Allergies or Hives | Epilepsy or Seizures |
| Heart Murmur | Diabetes | Fainting or Dizzy Spells |
| Heart Pacemaker | Hay Fever | Genital Herpes |
| Heart Surgery | Sinus Trouble | Glaucoma |
| Blood Pressure | Thyroid Disease | Hemophilia |
| High/Low | Colitis Rheumatism | Hepatitis A (infection) |
| Kidney Trouble | Sickle Cell Disease | Hepatitis B (infection) |
| Rheumatic Fever | Venereal Disease | Nervousness |
| Scarlet Fever Yellow | (Syphilis, Gonorrhea) | Pain in Jaw Joints |
| Jaundice | Arthritis | Psychiatric Treatment |
| Bruise Easily | Abnormal Bleeding | Cold Sores |
| | | Hearing Disabilities |

| | |
|---|---|
| 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 lost or gained more than 10 pounds in the past year? | □ Gained or lost more than 10 pounds in past year |

| | |
|---|---|
| | □ Did NOT gain or lose more than 10 pounds in last year |
| 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<br>If yes, what kind? ________<br>Quantity:________________ |
| Are you pregnant now? | □ Yes □ No |
| Approximate date of last medical examination: | ____/_____/_____ |
| Nearest relative not living with you. | Name:_________________<br>Relationship:___________<br>Phone:_________________ |
| Person to contact in case of an emergency. | Name:_________________<br>Relationship:___________<br>Phone:_________________ |

## HOW'S YOUR SLEEP?

Voller Dentistry diagnoses and treats sleep disorders. Please answer the following questions so we might help you sleep better.

| | |
|---|---|
| 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 you do wear a CPAP, when did you start wearing it? | ____/_____/_____ |

## JUST A FEW MORE QUESTIONS

| | |
|---|---|
| Voller Dentistry provides Juviderm Botox services to smooth wrinkles and take years off of your appearance. Would you be interested in learning more about Botox dermal filler? | □ Yes □ No |
| Be the face of Voller Dentistry!<br>I give my consent to have any study models and photographs of my face and mouth to be used for educational or promotional purposes. | Your Signature (or Parent if patient is under 18):<br>____________________<br>Date:____/_____/_____ |

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 fall.
Your Signature (or Parent if Patient is under 18):

______________________________________________

Date: _____/_____/_____

*Thanks for telling us a bit about yourself. We look forward to getting to know you better!*