Holistic Dental Arts Center
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☐ Mr
☐.Mrs
☐ Ms
☐ Dr

Date _____

_____ Pronunciation _____
Last First Middle

I prefer to be called: _____ Birth Date _____

Residence Address _____
Number Street City

_____ Residence Phone _____
State Zip Code (Area Code)

Cell Phone _____ Fax # _____ Email Address _____
(Area Code) (Area Code)

If less than one year, previous address _____
Number Street

_____
City State Zip Code

Social Security Number _____ Driver's License No. _____

Occupation _____ Employer _____

Employer Address _____ Wk Phone _____
Number Street City State Zip Code (Area Code)

Marital Status ____ Name of Spouse _____ Spouse SS# _____
Last First Middle

Spouse's Occupation _____ Employer _____

Employer Address _____
Number Street City

_____ Work phone _____
State Zip Code (Area Code)

Name of nearest relative not living with you _____ Address_____
Number Street

_____ Phone number _____
City State ZipCode (Area Code)

Who is legally responsible, if other than the patient? _____
Last First Middle

Relationship to patient _____

Address _____ Wk phone _____
Number Street City State Zip (Area Code)

By whom were you referred? _____

Dental insurance:

Name of other insured party _____ SS# _____

Date of Birth of other insured party _____

Employer_____

Insurance company (Carrier) name _____

Name of Group Plan _____ Group number _____

Address of insurance company

_____

Number Street City State Zip Code

Phone number of insurance company _____

(Area Code)

DENTAL HISTORY

Your answers to this dental history questionnaire will help us to understand your specific dental problems, so that we may more effectively treat you with consideration of your individual needs.

Previous dentist _____

Period of treatment _____

Address _____
Number Street City State Zip Code (Area Code) Phone

Specialty Dentist _____ Period of Treatment _____

Address _____
Number Street City State Zip Code (Area Code) Phone

What was accomplished at last dental visit? _____

Last complete mouth x-rays _____ Last complete dental exam _____

What is your immediate dental concern? _____

Please check YES or NO

1. Are you presently in pain? 1. YES [] NO []
   Teeth [] Which one(s)? _____
   Gums [] Jaw [] Face [] Other [] _____

2. Please note tooth sensitivity related to the following:
   Hot [] Cold [] Pressure from biting or chewing []
   Sweet [] Sour [] Grooves or recession at gumline []
   Other [] Where? _____ If so, is it (are they) a concern? 2. YES [] NO []

3. Do you have a burning sensation in your mouth? 3. YES [] NO []

4. Are you troubled with dryness in your mouth? 4. YES [] NO []

5. Have you ever had periodontal treatment or gum surgery? 5. YES [] NO []
   If YES, when? _____

6. Have you ever been informed that you had gum problems? 6. YES [] NO []
   If YES, when? _____

7. Do your gums feel tender or irritated? 7. YES [] NO []
   If YES, where? _____

8. Do your gums ever bleed when you brush your teeth? 8. YES [] NO []
   If YES, is it a concern? YES [] NO[]

9. Does food catch between your teeth? In general [] Specific area(s) [] 9. YES [] NO []
   If YES, is it a concern? YES [] NO []

10. Are you aware of a bad taste or odor in your mouth? 10. YES [] NO []
If YES, is it a concern? YES [] NO []

11. Does your skin become irritated when you wear jewelry? 11. YES [] NO []

12. Have you ever received professional instructions in oral hygiene? 12. YES [] NO []

13. Please indicate which items you use daily:
Hard-bristle toothbrush [] Proxi-brush [] Water spray [] Electric toothbrush [] Dental floss []
Soft-bristle toothbrush [] Rubber tip [] Stimudents or toothpicks [] Other []

14. Do you have your teeth cleaned on a regular basis? 14. YES [] NO []
If YES, how often?_____

15. Are you aware of any growths or swellings in your mouth? 15. YES [] NO []

16. Do you have frequent cold sores, canker sores or fever blisters? 16. YES [] NO []
on your gums, cheeks or lips?
If YES, how often? _____

17. Have you noticed any rough areas on your teeth? 17. YES [] NO []

18. Have you noticed any tooth mobility or looseness? If so, where? 18. YES [] NO []
If YES, is it a concern? YES [] NO []

19. Are you dissatisfied with or have a concern regarding the appearance of your teeth? 19. YES [] NO []
If so, in which category(ies)?
Discoloration/stain [] Alignment/Spacing [] Too "gummy" a smile []
Chipped teeth [] Worn edges [] All teeth wearing down/getting shorter []

20. Have you ever had any injury to, or soreness in your jaw joint(s)? (TMJ dysfunction) 20. YES [] NO []
[] Right joint [] Left joint [] Both joints

21. Do you have any chronic head, neck, shoulder or back problems? 21. YES [] NO []

22. Have you ever suffered trauma to your head, neck or jaw such as in a car accident? 22. YES [] NO []
If YES, please describe. _____

23. Are you aware of your jaw clicking, popping or making grating-like noises? 23. YES [] NO []
If YES, when? Where? Right [] Left [] Both [] Is it a concern? YES [] NO []

24. Have you currently [] In the past [] had Pain [] Locking [] of your jaw joints? 24. YES [] NO []
If YES, when? Where? Right [] Left [] Both [] Is it a concern? YES [] NO []

25. Any problems with other joints? 25. YES [] NO []

26. Do your jaw muscles feel []Tired []Stiff []Painful? If YES, is it a concern? YES [] NO [] 26. YES [] NO []

DENTAL HISTORY - 2 - PLEASE TURN PAGE

27. Do you have frequent headaches? [] Sinus problems? [] 27. YES [] NO []
Constant [] Intermittent [] Please circle degree of intensity: 1 2 3 4 5 6 7 8 9 10

28. Do you have frequent neckaches? 28. YES [] NO []
Constant [] Intermittent [] Please circle degree of intensity: 1 2 3 4 5 6 7 8 9 10

29. Do you ever have Pain [] or Ringing of the ears?[] If so, is it a concern? YES [] No [] 29. YES [] NO []

30. Do you ever experience vertigo, i.e., unexplained dizziness, balance problems? 30. YES [] NO []

31. Do you have pain/soreness around your eyes [] ears [] or other parts of your face?[] 31. YES [] NO []
Other _____

32. Are you aware of clenching your teeth during the day? If yes, is it a concern? YES[]NO[] 32. YES [] NO []

33. Do you feel as if your teeth don't have a "home base" to close to, or that your bite is changing? 33. YES [] NO []

34. Have you ever been told that you grind your teeth during sleep? 34. YES [] NO []
If YES, is it a concern? YES [] NO []

35. Have you ever had orthodontic treatment (braces)? 35. YES [] NO []

36. Do you have a "Fixed Bridge"? If YES, how long since it was placed? 36. YES [] NO []

37. Do you wear a removable complete or partial denture? 37. YES [] NO []
If YES, when do you wear it? _____ How long have you had it? _____

38. Have you ever had an unusual reaction to dental anesthesia (gas or 'shots')? 38. YES [] NO []
If YES, more than once? _____

39. Have you had any serious trouble associated with any previous dental treatment? 39. YES [] NO []
If YES, please explain _____

40. Are you anxious about dental treatment? If YES, circle the number which represents your level of anxiety, 10 being the most anxious. 1 2 3 4 5 6 7 8 9 10 40. YES [] NO []

41. Would you like sedation during your appointment? 41. YES [] NO []

Family Medical History

Please check any condition that applies to your parents (**M**other/**F**ather)

Heart disease []	M[] F[]	Cancer []	M[] F[]
Heart attack []	M[] F[]	Pre-term birth []	M[] F[]
High blood pressure []	M[] F[]	Gum disease []	M[] F[]
Stroke []	M[] F[]	Tooth loss []	M[] F[]
Low blood pressure []	M[] F[]	Dentures []	M[] F[]
Diabetes []	M[] F[]		

MEDICAL HISTORY

The thoroughness of this medical history is designed for your safety, and your complete answers will assist us in treating you with consideration for your special needs.

Family Physician _____ Date of last visit _____
Specialty _____ Date of last complete physical _____
Address _____
Number Street City State Zip Code (Area Code) Phone #

Additional Physician _____ Date of last visit _____
Specialty _____
Number Street City State Zip Code (Area Code) Phone #

Additional Physician or Health Provider, such as Chiropractor, Naturopath, Homeopath, Acupuncturist, etc.
_____ Date of last visit _____
_____
Number Street City State Zip Code (Area Code) Phone #

Please check YES or NO.

1. Do you have a current medical problem? 1. YES [] NO []
   If yes, please explain _____
_____

2. Are you currently under the care of a physician? 2. YES [] NO []
   If yes, who? _____

3. Have you been hospitalized or had a serious illness within the past 5 years? 3. YES []NO []
   If YES, please explain _____
4. Do you have heart trouble or any form of cardiovascular disease? 4. YES [] NO []
   If YES, indicate below:
   [] Angina (chest pains) Frequency _____
   [] Heart Attack (date) _____
   [] Heart Surgery (date) _____
   [] Pacemaker
   [] Bypass
   [] Prosthetic heart valve
   [] Stroke (date) _____
   [] Rheumatic Fever (date) _____
   [] Heart Murmur
   [] High Blood Pressure
   [] Low Blood Pressure
   [] Congenital Heart lesions
   [] Atherosclerosis
   [] Other
   [] Blood Pressure, if known _____/_____

5. Are you ever short of breath after mild exercise? 5. YES [] NO []
6. Do your ankles swell? _____ 6. YES [] NO []
7. Do you get short of breath when you lie down, or do you require extra pillows when you sleep? _____ 7. YES [] NO []
8. Do you have diabetes? _____ . YES[] NO[] Prediabetes?_____ 8. YES [] NO []
   If YES, how is it controlled? Diet [] Oral Medication [] Injections []
9. Do you have hypoglycemia? 9. YES [] NO []
   If YES, how is it controlled? _____
10. Do you have kidney disease? 10. YES [] NO []

11.Have you ever had hepatitis? (Date)_____ 11. YES [] NO []
Type A Infectious (Food) [] Type B Serum (Blood) [] Type C (non-A, non-B) []
Unknown [] (Explain) _____
12.Have you ever had liver disease or jaundice? (Date) _____ 12. YES [] NO []
13.Do you have any blood disease? 13. YES [] NO []
Anemia [] AIDS or HIV positive test [] Leukemia []
Venereal disease [] Other [] _____
14.Do you have any problems with excessive bleeding? 14. YES [] NO []
If YES, please explain. _____
15.Do you bruise easily? 15. YES [] NO []
16.Do you have stomach or intestinal ulcers? 16. YES [] NO []
17.Have you ever had tuberculosis? (Date) _____ 17. YES [] NO []
18.Do you have emphysema, asthma or breathing problems? 18. YES [] NO []
19.Do you have any form of arthritis? 19. YES [] NO []
Rheumatoid Arthritis [] Gout/Gouty Arthritis []
Osteoarthritis [] Other [] _____
Which joints are involved?
_____
20. Do you have any orthopedic or tissue repair implants in your body such as pins, 20. YES [] NO []
plates, screws or artificial joints? If yes, please list them as best you can.
_____
21.Do you have fainting spells, convulsions or epilepsy? 21. YES [] NO []
22.Have you had surgery, radiation or treatment for a tumor or growth? 22. YES [] NO []
If YES, what area(s)? _____
23.Do you have glaucoma? 23. YES [] NO []
Right eye [] Left eye [] Both eyes []
24.Your height _____
25.Current body weight _____ Have you gained [] or lost [] weight within the last year? 25. YES [] NO []
How much? _____
26.Is your diet medically prescribed? 26. YES [] NO []
If YES, please explain. _____
27.Are you taking vitamins? 27. YES [] NO []
What kind and dosages? _____
28. Are you currently taking any herbal medicines? 28. YES [] NO []
If so, what kind? _____
29.Are you using food supplements? 29. YES [] NO []
What? _____
30.Do you frequently not eat breakfast? 30. YES [] NO []
31.Do you become fatigued easily? 31. YES [] NO []
At what time of day? _____
32 Have you been told, or are you aware that you have a tendency for snoring? 32. YES [] NO []
33 Do you feel rested after 7 hours of sleep? 33. YES [] NO []
34. Are you sleepy or do you feel you are dragging during the day? 34. YES [] NO []

Questions 35-36 For Women

35.Is there a possibility that you may be pregnant? 35. YES [] NO []
(If so, expected delivery date) _____
36.Do you have a history of miscarriages? 36. YES [] NO []

37.Are you allergic to or have you had any unusual reaction to any of the following? 37. YES [] NO []

[] Penicillin
[] Erythromycin
[] Sulfa drugs
[] Other antibiotics_____
[] Codeine
[] Aspirin
[] Sleeping pills
[] Barbiturates
[] Other pain medications_____
[] Local anesthetics
[] Novocaine
[] Xylocaine
[] Nitrous oxide
[] Epinephrine
[] Any other drug allergies? _____

38.Have you ever been advised not to take a particular medication? 38. YES [] NO []
If YES, please list. _____

39.Have you ever been advised to take prophylactic antibiotics before dental treatment? 39. YES [] NO []

40.Have you ever used Phen Fen or other appetite suppression combinations for weight loss? 40. YES [] NO []
If the answer to question #39 is positive, have you had an echocardiogram?

41.Are you taking/have you taken bisphosphonate medication (Zometa, Fosomax, Didronel, Actonel, Aclasta?) If so, for how long/how long ago? _____ 41. YES [] NO []

Please indicate if you are taking any of the following medications:

	Name	Purpose	Frequency	Since
[] Heart Medication_____				
[] Blood Pressure Medication_				
[] Cholesterol lowering_____				
[] Insulin_____				
[] Nitroglycerine_____				
[] Blood Thinner Medication_				
[] Antibiotics_____				
[] Sedatives_____				
[] Tranquilizers_____				
[] Anti Depressants_____				
[] Pain Medication_____				
[] Cortisone (Steroids)_____				
[] Thyroid_____				
[] Birth Control Pills_____				
[] Over Counter Medications_				
[] Medicinal Patches_____				
[] Other_____				

Please name the pharmacy you use. _____ city _____ phone (__) _____

[] Alcohol (_____) drinks per day
[] Tobacco (_____) packs per day for approximately (_____) years
[] "Recreational" drugs such as cocaine, marijuana, stimulants or depressants may have a fatal interaction with local anesthetics or other common dental medications. Please describe the use of any drugs or discuss in complete confidentiality with the doctor._____

42. Is there a disease, condition or problem not listed above that you think I should know of? 42. YES [] NO []
If yes, what? _____

To the best of my knowledge, all the preceding answers are true and correct. If I have any change in my health or medications, I will inform the doctor at my next appointment. If deemed advisable, I grant permission for my physician to be contacted for details and advice. I further authorize the taking of radiographs, photographs, or other diagnostic measures appropriate for a thorough evaluation. Authorization is also given for dental treatment to be rendered by the dentist and office staff, and I will assume financial responsibility.

Signature _____ Date _____