

Patient Care Information



PAPADAKIS
GONZALEZ

Name _____ LAST _____ FIRST _____ MIDDLE _____ ? Male ? Female

Birth Date _____ Please Check ? Single ? Married ? Divorced ? Seperated ? Widowed

Home Phone _____ Business Phone _____ Social Security # _____

Home Address _____ STREET _____ CITY _____ STATE _____ ZIP _____

Business Address _____ STREET _____ CITY _____ STATE _____ ZIP _____

Home e-mail Address _____ Business e-mail Address _____

Employer _____ Present Position _____

Name of Spouse _____ Names of Children _____

Spouse's Employer _____ Present Position _____

Name of person to notify in an emergency _____

Relationship _____ Phone _____

Address _____ STREET _____ CITY _____ STATE _____ ZIP _____

Previous D.D.S. _____ Last Seen _____

Address _____ STREET _____ CITY _____ STATE _____ ZIP _____ Phone _____

Physician's Name _____ Last Seen _____

Address _____ STREET _____ CITY _____ STATE _____ ZIP _____ Phone _____

Person responsible for my account _____

Name(s) of other family members seen here _____

Whom may we thank for this referral? _____

For Patients with Dental Insurance

Primary Insurance _____ Subscriber's Name _____

Subscriber's Employer _____ Subscriber's Soc. Sec. # _____ Subscriber's Birth Date _____

Name of Insurance Plan _____ Group # _____

Insuarnce Plan Address _____ STREET _____ CITY _____ STATE _____ ZIP _____

Secondary Insurance _____ Subscriber's Name _____

Subscriber's Employer _____ Subscriber's Soc. Sec. # _____ Subscriber's Birth Date _____

Name of Insurance Plan _____ Group # _____

Insurance Plan Address _____ STREET _____ CITY _____ STATE _____ ZIP _____

Patient Care Information

Providing you with comprehensive care in a calm and comforting environment is our greatest concern. It is an important part of our philosophy to understand your needs, values, and concerns. For this reason, we ask you to please share the following information about yourself.

Your approximate age at first dental appointment _____

2. Was care regular? Yes No

3. How much decay did you have as a child? A lot Average Very little

4. What were your parents' dental conditions and care habits? _____

5. Describe the last five years of your dental care _____

6. Have you ever had:

orthodontic treatment? Yes No

oral surgery? Yes No

your bite adjusted? Yes No

root canal treatment? Yes No

7. Do you experience sensitivity to heat, cold or pressure? Yes No

8. Does food get caught between your teeth? Yes No

9. Do you brush your teeth: Vigorously Moderately Lightly

10. How often do you brush your teeth? _____

11. How often do you floss your teeth? _____

12. Have you ever had professional instructions in home care? Yes No

13. Habits — Do you:

clench your teeth during the day? Yes No

clench your teeth during the night? Yes No

bite your lips or cheeks regularly? Yes No

hold foreign objects with your teeth? (pencils, fingernails, pipe, etc.) Yes No

mouth breathe while awake or asleep? Yes No

chew tobacco? Yes No

smoke? Yes No

consume alcohol daily? Yes No

14. Problems of the jaw. Have you ever experienced:

clicking of the jaw? Yes No

pain (joint, ear, side of face)? Yes No

difficulty in chewing? Yes No

chronic neck or shoulder pain? Yes No

chronic headaches? Yes No

15. Have you noticed any loosening of your teeth? Yes No

16. Do you suffer from pain and/or swelling of your gums? Yes No Any pus around the gums? Yes No

17. Do your gums often bleed when you floss or brush your teeth? Yes No

18. Have you ever suspected you have mouth odor? Yes No

19. Have you ever heard of periodontal disease? Yes No

20. Do you have any missing teeth? Yes No

How long have they been missing? _____

Why didn't you have them replaced? _____

Was it ever suggested? _____

21. Can sugar be found frequently in your daily diet? Yes No

Is it consumed with meals? Yes No

Is it consumed between meals? Yes No

22. Do you take a daily vitamin supplement? Yes No Please describe _____

23. Are the five good food groups part of your meals? Yes No

24. How can we help you? (i.e. your expectations, needs, and concerns) What is important to you? What are you looking for in a dental office?

Expectations _____

Needs _____

Concerns _____

25. Do you think dental disease is active or controlled in your teeth and tissues? Active Controlled

26. Is your general health and dental health a value of yours? Yes No

27. How would you rate your present general health? (1 = Poor, 10 = Good) 1 2 3 4 5 6 7 8 9 10

Why? _____

28. How would you rate your present dental health? (1 = Poor, 10 = Good) 1 2 3 4 5 6 7 8 9 10

Why? _____

29. Have you had any particularly good or bad experiences in dentistry? Please explain _____

30. Do you have any dental anxieties? Yes No Please explain _____

31. Do you go to a dentist to be cared for, to learn to become more healthy, or both? Cared for More healthy Both

32. If you were given a magic wand and could change anything about your smile and/or dental health what would it be? _____

33. What are your dental health goals 5 to 10 years from now and for the rest of your life? _____

34. In your opinion, what prevents you from achieving your dental health goals? _____

35. Has a dental team ever helped you set up a plan so you could be successful with your dental goals? Yes No

36. How do you enjoy spending your free time? _____

1. Do you feel you are in good health? Yes No

Has there been any change in your general health in the past year? Yes No

If so, please explain _____

2. When was your last physical? _____

3. Are you under the care of a physician? Yes No

4. The following conditions may need a pre-medication before any dental procedure. Please check any of the conditions that apply to you now or have in the past.

- heart murmur mitro valve prolapse artificial valve rheumatic fever
- artificial joint prosthesis surgery with pins open heart surgery

5. Please check any of the following that apply to you now or have in the past.

- Heart Disease Hay fever Nervous disorder Radiation therapy Fainting spells
- Depression Tuberculosis Seizures Counseling Venereal disease
- Abnormal blood pressure Diabetes Hepatitis A Jaundice Pacemaker
- AIDS/ARC Blood relatives with diabeters Hepatitis B Abnormal bleeding Ulcers
- Excessive urination or thirst Anemia Hepatitis C Blood transfusion Kidney trouble
- Epilepsy Cancer Bruise easily Emphysema Tumor
- Glacoma Transplant surgery Asthama Arthritis Other _____

6. Please check any of the following mediciations you are taking

- Antibiotics or sulfa drugs Ditigalis or drug for heart trouble Other _____
- Anticoagulants (blood thinners) Nitroglycerin _____
- Medication for high blood pressure Antihistamine _____
- Steroids Birth Control Pill _____
- Tranquilizers MAO inhibitors (i.e. Marplan, Nardil, Parnar) _____
- Insulin, Tolbutamide (orinase or similar drug) Antidepressants (i.e. Prozac, Lithium, Tegrel) _____

7. Please check if you are allergic to any of the following.

- Local anesthetics Asprin Bi-Sulfites
- Penicillin or other antibiotics Barbiturates, sedatives or sleeping pills Other _____
- Iodine, Seafood Codeine, other narcotics _____
- Sulfa drugs Latex sensitivity _____

8. (Women) Are you pregnant? Yes, due date is _____ No

9. Have you had serious trouble with previous dental treatment? Yes No If so please explain

Signature _____ Date _____

Medical Update: Note changes, date, and sign

Date B.P. Notes	<input type="checkbox"/> No change	Date B.P. Notes	<input type="checkbox"/> No change	Date B.P. Notes	<input type="checkbox"/> No change
Date B.P. Notes	<input type="checkbox"/> No change	Date B.P. Notes	<input type="checkbox"/> No change	Date B.P. Notes	<input type="checkbox"/> No change
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