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COMPREHENSIVE DENTISTRY

Date : _____

REGISTRATION AND HEALTH HISTORY

Name: _____ Social Security #: _____

Name we should call you: _____ Date of Birth: _____

Home Phone #: _____ Cell #: _____ E-mail Address: _____

Address: _____ City/State/Zip _____

Employed By: _____ Driver's Lic # and State Issued _____

Position: _____ Work Phone# _____

Marital Status: _____ Spouse's Name: _____

Spouse's SS#: _____ Spouse's Date of Birth: _____

Spouse Employed By: _____

Position: _____ Work Phone#: _____

Nearest Relative (In case of emergency): _____

Phone #: _____ City & State: _____

Who may we thank for referring you to our practice? _____

Who will pay your account? _____

Purpose of this visit: _____

INSURANCE INFORMATION:

Name of Primary Dental Insurance Company: _____

Employer that Carries Insurance: _____

Address of Primary Dental Insurance Co: _____

Name of Employee/Policy Holder: _____ Group #: _____

Member/Subscriber/Employee ID # (If Applicable) _____

MEDICAL HISTORY:

Name & phone # of Primary Care Physician: _____

Date of your last complete physical: _____

Please Complete the Separate MEDICAL HISTORY FORM

Initial Visit Interview

- Dr.
- Mr.
- Mrs.
- Miss
- Ms. _____ Date _____
Last First Middle Initial

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

Previous Dentist _____ Specialty _____

Period of Treatment _____ Date of Last Visit _____

Address _____
Number Street City State Zip Code (area code) Phone

What is your immediate dental concern? _____

Please check YES or NO (or circle one).

1) I think I am:

- In Excellent oral health.
- In Good oral health.
- In Poor oral health.

2) I desire:

- Excellent oral health.
- Average or Good oral health.
- Crisis Care only.

3) Are you presently in pain? **YES** or **NO**

- Teeth
- Gums
- Jaw
- Face
- Other _____

4) Is any part of your mouth sensitive to the following? **YES** or **NO**

- Hot
- Cold
- Sweet
- Sour
- Pressure
- Other _____

- 5) Do you have a burning sensation in your mouth? **YES** or **NO**
- 6) Are you troubled with dryness in your mouth? **YES** or **NO**
- 7) Do you have any pain or soreness around your ears, cheeks, or other parts of your face? **YES** or **NO**
- 8) Do you have chronic headaches? **YES** or **NO**
- 9) Have you ever had periodontal treatment or gum surgery? **YES** or **NO**
If Yes, when? _____ By Whom? _____
- 10) Have you ever been informed of any gum problems? **YES** or **NO**
If Yes, when? _____ By Whom? _____
- 11) Do your gums bleed when you brush your teeth? **YES** or **NO**
- 12) Does food catch between your teeth? **YES** or **NO**
- 13) Do you drink sodas/pop? **YES** or **NO**
- 14) Are you aware of a bad taste or odor in your mouth? **YES** or **NO**
- 15) Please indicate which items you use daily.
- Hard-bristle toothbrush
 - Soft-bristle toothbrush
 - Electric toothbrush
 - Proxi-brush
 - Rubber Tip
 - Dental Floss
 - Water Spray
 - Stimulents or toothpicks
 - Other _____
- 16) Are you aware of any growths or swelling in your mouth? **YES** or **NO**
If Yes, Where are they located and how long have they existed? _____

- 17) Do you have frequent cold sores, canker sores, or fever blisters on your gums, cheeks or lips? **YES** or **NO** If Yes, how often? _____
- 18) Are you aware of your jaw clicking, popping, or making grating-like noises? **YES** or **NO** If Yes, when? _____
- 19) Do your jaw muscles feel tired, stiff or painful? **YES** or **NO**
- 20) Do you chew gum? **YES** or **NO**
- 21) Are you aware of clenching your teeth during the day? **YES** or **NO** If Yes, how often?

- 22) Have you ever been told that you grind your teeth during your sleep? **YES** or **NO** If Yes, how often? _____
- 23) Do you wear a removable denture or appliance? **YES** or **NO** If Yes, when do you wear it? _____
- 24) Are you frustrated by needing constant dental repair because of active dental disease? **YES** or **NO**
- 25) Are you anxious about dental treatment? **YES** or **NO**
- 26) Do you have any disease or known condition which has not been addressed in the above. That you feel is important for us to know? If Yes, please explain: _____

27) My mouth is:

- Very Comfortable.
- Moderately Comfortable.
- Uncomfortable.

28) I:

- Think the appearance of my mouth is excellent.
- Think the appearance of my mouth is adequate.
- Wish I could change the appearance of my mouth.

If so, what would you change? _____

29) I:

- Want to save my teeth at all costs.
- Prefer to keep my teeth if cost and time are reasonable.
- Am not very interested in setting personal goals to achieve optimum oral health.

30) I:

- Have followed the recommendations for optimum dental health given by my dentist.
- Have not done what dentists recommended I do with my mouth.
- Usually only go to the dentist for emergencies.

31) What are some questions about dentistry and your oral health that you have never had adequately answered? _____

As it relates to my medical history, all of the preceding answers are true and correct to the best of my knowledge. If I ever have a change in my health, or if my medications change, I will inform Dr. Hatcher or his staff at my next dental appointment without fail. (Insurance patients only: I authorize release of any information relating to dental insurance claims.) I understand that I am responsible for all costs of dental treatment and that before credit is extended, a credit report will be obtained.

Signature _____ Date _____