Dentistry At Clarkson

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The personal information provided below will be protected and kept private by our office. All information will be used and disclosed responsibly according to the Private Act standards set up and monitored by our office.

☐ Mr. ☐ Mrs. ☐ Miss. ☐ Ms. ☐ Dr. Name: ______________________ Last Name: ______________________

Prefer to be called: __________________ Pronunciation: __________________ Date of birth: __________ (MM/DD/YY)
Marital Status: __________________

Address: ______________________________ (STREET) ________ (APT.#) _______________________ (CITY) ______________ (POSTAL CODE)

Home Phone: (_____) -_________-__________ Email Address: ______________________________________

Mobile Phone:(_____) -_________-__________ Preferred Contact Method: ____________________________

Are you likely to be available on short notice for future appointments? ☐ Yes ☐ No

How did you find out about our office?
☐ Google ☐ Internet ☐ Smiles Savers Program ☐ Referral ☐ Other: ___________________________________
If referred, who may we thank for referring you to our office? ______________________________________

Family Physician: ___________________________ Phone: (_____)-_________-__________

Emergency Contact: _________________ Relation: _______________ Phone: (_____)-_________-__________

Person Responsible for this Account: ☐ Self ☐ Spouse ☐ Parent ☐ Legal Guardian ☐ Others

Name: ______________________ Last Name: ________________________ Relation: _____________________

☐ Same address as above – If different please fill below.
Address: ______________________________ (STREET) ________ (APT.#) _______________________ (CITY) ______________ (POSTAL CODE)

Home Phone: (_____)-_________-__________ Email Address: ______________________________________

PRIMARY INSURANCE	SECONDARY INSURANCE
Subscriber: _________________________________	Subscriber: _________________________________
Date of Birth: _______ /_______ /_______ (DD MM YR)	Date of Birth: _______ /_______ /_______ (DD MM YR)
Relation: ☐ Self ☐ Spouse ☐ Parent	Relation: ☐ Self ☐ Spouse ☐ Parent
Insurance Company: _________________________	Insurance Company: _________________________
Policy/Plan #: ______________________________	Policy/Plan #: ______________________________
ID/Certificate #: ____________________________	ID/Certificate #: ____________________________
Are you familiar with your dental plan? ☐ Yes ☐ No	***Are you familiar with your dental plan?*** ☐ Yes ☐ No

Method of Payment: ☐ Cash ☐ Debit ☐ Credit Card: ___________________________________ Exp: __________ (MM / YR)

DENTAL HISTORY

How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Previous Dentist: ________________________ How long have you been a patient? _______________ Months/Years
Date of most recent dental exam: _______________________ Date of most recent x-rays: __________________________
Date of most recent treatment (other than a cleaning): ______________________
I routinely see my dentist every: ☐ 3 months ☐ 4 months ☐ 6 months ☐ 12 months ☐ not routinely
What is your immediate concern? ____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY

#	Question	YES	NO
1.	Are you fearful of dental treatment? How fearful on a scale of 1 (least) to 10 (most) [______] ___________________________	☐	☐
2.	Have you ever had an unfavorable dental experience? ____	☐	☐
3.	Have you ever had complications from past dental treatment? ____	☐	☐
4.	Have you ever had trouble getting numb or had any reactions to local anesthetic? ___________________________	☐	☐
5.	Did you ever have braces, orthodontic Treatment or had your bite adjusted? ________________________________	☐	☐
6.	Have you had any teeth removed? ____	☐	☐
	SMILE CHARACTERISTICS		
7.	Is there anything about the appearance of your teeth that you would like to change? ___________________________	☐	☐
8.	Have you ever whitened (bleached) your teeth? ____	☐	☐
9.	Have you felt uncomfortable or self-conscious about the appearance of your teeth? ___________________________	☐	☐
10.	Have you been disappointed with the appearance of previous dental work? ___________________________________	☐	☐
	BITE AND JAW JOINT		
11.	Do you have problems with your jaw joint? (Pain, sounds, limited opening, locking, popping) ____________________	☐	☐
12.	Do you/would you have any problems chewing gum? ____	☐	☐
13.	Do you/ would you have any problems with chewing bagels, baguettes, protein bars or other hard foods? _____________	☐	☐
14.	Have your teeth changed in the last 5 years, become shorter, thinner, or worn? _______________________________	☐	☐
15.	Are your teeth crowding or developing spaces? ____	☐	☐
16.	Do you have more than one bite and squeeze to make your teeth fit together? ________________________________	☐	☐
17.	Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? __________________	☐	☐
18.	Do you clench your teeth in the daytime or make them sore? ____	☐	☐
19.	Do you have any problems with sleep or wake up with an awareness of your teeth? ____________________________	☐	☐
20.	Do you wear or have you ever worn a bite appliance? ____	☐	☐
	TOOTH STRUCTURE		
21.	Have you had any cavities within the past 3 years? ____	☐	☐
22.	Does the amount of saliva in your mouth seem to little or do you have difficulty swallowing any food? _______________	☐	☐
23.	Do you feel or notice any holes (i.e., pitting, craters) on the biting surface of your teeth? _______________________	☐	☐
24.	Are any sensitive to hot, cold, biting sweets, or avoid brushing any part of your mouth? _________________________	☐	☐
25.	Do you have grooves or notches on your teeth new the gum line? ____	☐	☐
26.	Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? ____________________________	☐	☐
27.	Do you frequently get food caught between your teeth? ____	☐	☐
28.	Do your gums bleed or are they painful when brushing or flossing? ____	☐	☐
	GUM AND BONE		
29.	Have you ever been treated for gum disease or been told you have lost bone around your teeth? _________________	☐	☐
30.	Have you ever noticed an unpleasant taste or odor in your mouth? ____	☐	☐
31.	Is there anyone with a history of periodontal disease in your family? ____	☐	☐
32.	Have you ever experienced gum recession? ____	☐	☐
33.	Have you ever had any teeth become loose on their own (without injury), or do you have difficulty eating an apple? _________	☐	☐
34.	Have you experienced a burning sensation I your mouth? ____	☐	☐

MEDICAL HISTORY

The following is required by the dentist to assist in proper diagnosis and treatment.

1. Have you ever had a serious illness requiring hospitalization or extensive medical care? ☐ Yes ☐ No
   Please Specify:
   ____
2. Are you Presently under the care of a physician? ☐ Yes ☐ No
   Please Specify:
   ____
3. Have you had a medical examination in the last year? ☐ Yes ☐ No
4. Do you use any prescription or non-prescription drugs regularly? ☐ Yes ☐ No
   Please Specify:
   ____
5. Do you have allergic conditions: e.g., hay fever, skin rash, food allergies, metal, latex? ☐ Yes ☐ No
6. Do any allergic reactions result in headaches, shortness of breath, chest constriction, nausea? ☐ Yes ☐ No
7. Have you been hospitalized in the last 5 years? ☐ Yes ☐ No
8. Have you ever experienced any unusual reaction to any of the following?
   ☐ Local anesthesia ☐ Aspirin ☐ Penicillin
   ☐ Codeine ☐ Sulpha drugs ☐ Barbiturates (sleeping pills)
   ☐ Any other Medicine.
   Please Specify: ____
9. Have you been warned against taking any drugs or medication? ☐ Yes ☐ No
10. Do you bruise easily or bleed abnormally? ☐ Yes ☐ No
11. Do you require pre-medication for dental treatment? ☐ Yes ☐ No
12. Have you ever had any organ implants or medical implants? ☐ Yes ☐ No
13. Have you ever fainted? ☐ Yes ☐ No
14. Do you your ankles swell? ☐ Yes ☐ No
15. Do you experience shortness of breath, chest pain when taking a walk or climbing stairs? ☐ Yes ☐ No
16. Do you have frequent headaches? ☐ Yes ☐ No
17. Do you had A.I.D.S or have you ever tested positive for H.I.V.? ☐ Yes ☐ No
18. Do you have any of the following? *Please check all that apply.*
    ☐ Arthritis or Rheumatism ☐ Cancer/ Chemotherapy ☐ Cold Sores
    ☐ Cortisone/ Steroid Therapy ☐ Diabetes ☐ Drug/Alcohol Dependency
    ☐ Emphysema ☐ Epilepsy or Seizures ☐ Glaucoma
    ☐ Heart Attack ☐ Heart murmur/Mitral Valve Prolapse ☐ Hepatitis A / B / C
    ☐ Herpes ☐ High Blood Pressure ☐ Hyper Glycemia
    ☐ Jaundice ☐ Joint Replacement (i.e., Hip, knee) ☐ Kidney Problems
    ☐ Liver Disease ☐ Low Blood Pressure ☐ lung disease (i.e., Asthma)
    ☐ Malignant Hyperthermia ☐ Mental/Nervous Disorder ☐ Scarlet or Rheumatic Fever
    ☐ Sinus Trouble ☐ Stomach/Intestinal Problems/ Ulcers ☐ Stroke
    ☐ Thyroid Disease ☐ Tuberculosis ☐ Venereal Disease
    ☐ Other: ____
19. Have you had any injury, surgery, or x-ray therapy to your face or jaws? ☐ Yes ☐ No
20. Do you have any disease, condition, or problem that you think the doctor should know about? ☐ Yes ☐ No
    If Yes, Please Specify:
    ____
21. ***WOMEN ONLY –*** Are you pregnant or suspect you might be? ☐ Yes ☐ No
    If Yes, what month are you in? ______________________________
    Are you taking birth control? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

PRIVACY ACT NOTIFICATION

I have been informed of the privacy policy of this office and understand that all information I have supplied will be used and disclosed as set out within this office policy.

OFFICE POLICY

Your appointment time will be reserved for you. If you are unable to keep the appointment, we will require a 48-hour cancellation notice, otherwise it may be necessary to charge you for time lost.

PATIENT RELEASE

I, the undersigned, certify that I have provided an accurate and complete personal and medical dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any question regarding my medical-dental history. I authorize the dentist to preform diagnostic with my medical doctor may be required, and I consent to my physician being contacted as necessary. I understand that my responsibility for my payment for the dental services provided for my dependents and myself is mine, and I will assume responsibility for fees associated with these services.

(*Signature*)

______/ ______/ ______
MM DD YR

☐ Patient ☐ Parent ☐ Legal Guardian

Reviewing Dentist: ____