

## AESTHETIC COMPREHENSIVE DENTISTRY

We are a health- centered dental practice, thus we are concerned with your total well being, not just your oral health. An essential part of our approach is a thorough health history. Please fill out the health questionnaire below completely- even if some of the question may not seem relevant to your dental health. Thank you!

Full Name \_\_\_\_\_ Date \_\_\_\_\_

Preferred Name \_\_\_\_\_ Soc.Sec.No. \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Weight \_\_\_\_\_ Height \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_ Divorced \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

E- Mail \_\_\_\_\_

What are your hobbies or special interests? \_\_\_\_\_

\_\_\_\_\_

Person to contact in case of emergency \_\_\_\_\_ Phone # \_\_\_\_\_

Whom should we thank for your Referral \_\_\_\_\_

### **Health and Dental History**

Physician's Name \_\_\_\_\_ Phone # \_\_\_\_\_

Are you taking any medication now, including regular dosages of Aspirin?    Yes    No  
If so, please list name and dosage \_\_\_\_\_

\_\_\_\_\_

Are you aware of having an allergic reaction to any medication or substance?    Yes    No  
If so, please list \_\_\_\_\_

Have you been under the care of a medical doctor during the past two years?    Yes    No  
If so, for what? \_\_\_\_\_

Have you seen an ENT (ear, nose and throat doctor)? Yes    No    Name \_\_\_\_\_

Have you seen a Chiropractor? Yes    No    Name \_\_\_\_\_

Have you seen a Neurologist?    Yes    No    Name \_\_\_\_\_

Have you had braces?                      Yes    No    Name \_\_\_\_\_

Have you ever had any cosmetic procedure?    Yes    No    If so, for what? \_\_\_\_\_

\_\_\_\_\_

Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart Concerns	Yes No	Arthritis	Yes No
Congenital Heart Disease	Yes No	Tuberculosis	Yes No
Heart Murmur	Yes No	Lung Disease	Yes No
Rheumatic Fever	Yes No	History of Cancer	Yes No
Low/High Blood Pressure	Yes No	Thyroid Problems	Yes No
Mitral Valve Prolapse	Yes No	Stomach Problems/ Ulcer	Yes No
Artificial Heart Valve	Yes No	Migraines	Yes No
Pacemaker	Yes No	Headaches	Yes No
Stroke	Yes No	Jaw Pain	Yes No
Asthma	Yes No	Jaw Popping	Yes No
Liver Disease	Yes No	Limited Opening	Yes No
Latex Sensitivity	Yes No	Congested Ears	Yes No
Artificial Joints	Yes No	Dizziness	Yes No
Kidney Problems	Yes No	Ringling Ears	Yes No
Radiation/ Chemotherapy	Yes No	Loose Teeth	Yes No
Epilepsy/ Seizures	Yes No	Posture Problems	Yes No
Diabetes	Yes No	Clenching/ Grinding	Yes No
Hepatitis	Yes No	Facial Pain	Yes No
AIDS/ HIV	Yes No	Sensitive Teeth	Yes No
Sickle Cell Disease	Yes No	Neck Ache	Yes No
Neurological Disorders	Yes No	Bell's Palsy	Yes No
Psychological Disorders	Yes No	Difficulty Swallowing	Yes No
Sinusitis	Yes No	Difficulty Chewing	Yes No
Muscle Relaxant	Yes No	Trigeminal Neuralgia	Yes No
Blood Thinner	Yes No	Tingling in arms/fingers	Yes No
Excessive Bleeding	Yes No	Insomnia/ frequent waking	Yes No

Does floss shred when you use it?	Yes No
Does food pack or catch between your teeth?	Yes No
Do you smoke or chew tobacco?	Yes No
Do your gums bleed?	Yes No
Does your breath concern you?	Yes No

**Women:** Are you: Pregnant? \_\_\_\_\_ Nursing? \_\_\_\_\_ Taking birth control pills? \_\_\_\_\_

Do you have or have you had any surgery, disease, condition or problem not listed? Yes No  
If so, please list \_\_\_\_\_

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider who may release such information to you. I will notify the doctor of any change in my health or medication.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Our office is like no other dental office. This will be the most important dental visit you will ever have. We place a high emphasis on helping you determine your present and future dental needs. Here are the topics we are going to be talking about at your first visit. . Please check what best expresses how you feel about the following questions:

- Are you having any areas of concern? \_\_\_\_\_
- Tell us, in your opinion, What you think the present state of the health of your mouth is? \_\_\_\_\_  
\_\_\_\_\_
- What do you already know about our office and what are your expectations? \_\_\_\_\_  
\_\_\_\_\_
- How healthy do you want us to get your mouth?  
Don't really care                      Average                      the best it can be
- Should you need treatment, at what point should we address it?  
    \_\_\_ When my tooth hurts or breaks  
    \_\_\_ When something is worsening  
    \_\_\_ When something isn't ideal
- What quality of dentistry do you want us to recommend?  
    Just patch it                      Average                      Ideal/ the best
- We have the ability to look at your mouth from 3 different perspectives. What combination of these would you like us to use for you? ( please circle)  
    As a **general** dentist                      As a **cosmetic** dentist                      As a **functional** dentist
- How do you feel about the appearance of your face and smile? \_\_\_\_\_  
\_\_\_\_\_
- What would it take for you to trust us to be your dentist? \_\_\_\_\_  
\_\_\_\_\_
- Tell us about your **good** dental experience... \_\_\_\_\_  
And the **bad** ones... \_\_\_\_\_
- Has fear ever been an issue for you in a dental office? \_\_\_\_\_
- What caused you to leave your last dental office? \_\_\_\_\_
- Has time ever been a factor in getting your dental work done? \_\_\_\_\_
- Has the cost of dental treatment been a concern for you? \_\_\_\_\_  
What can we do to help you with this? \_\_\_\_\_
- Is there any additional information you would like us to know? \_\_\_\_\_  
\_\_\_\_\_