New Patient

501 W. Lakeway Road
Gillette, WY 82718
307-682-3100
www.mysynergydental.com

Patient Name:

MEDICAL / DENTAL HISTORY

Please check all that apply:

- ☐ Sensitivity
- ☐ Tooth Pain or discomfort when chewing
- ☐ Headaches, earaches, neck pain
- ☐ Jaw joint pain
- ☐ Teeth or fillings breaking
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose, tipped or shifting teeth
- ☐ Bad breath or bad taste in your mouth

On a scale of 1-10, with 10 being the highest rating:

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Where do you want your dental health to be?

1 2 3 4 5 6 7 8 9 10

Home Care Routine:

How often do you brush? ____________

How often do you floss? _____________

How often do you Waterpik?__________

If you could whiten your teeth at a cost anyone could afford, would you? Yes / No

If I could change my smile, I would:

- ☐ Make them brighter
- ☐ Make them straighter
- ☐ Close spaces
- ☐ Replace black metal fillings with tooth-colored fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match
- ☐ Other____________________________

What is the most important thing to you about your future smile and dental health?

____

____

What is the most important thing to you about your dental visit today?

____

____

MEDICAL / DENTAL HISTORY

Caries (tooth decay):

Do you consider yourself cavity prone?.....................Y N

Do you consume sugary foods or beverages on a regular basis? ....Y N

Do you consume any citrus flavored beverages?.......Y N

Does your mouth feel dry? ....Y N

Do you have heartburn or reflux? ....Y N

Periodontal Disease:

Have you been told you have gingivitis or gum disease in the past?..Y N

Do your gums ever bleed when you brush or floss? ....Y N

Do you have gum recession or exposed root surfaces? ....Y N

Do you have any loose teeth, drifting teeth, or areas that collect food when you eat? ....Y N

Dependency/Addiction:

Are you currently in recovery or being treated for addiction? .... Y N

Do you smoke or chew tobacco? .... Y N

If yes, do you want to quit? .... Y N

Do you depend on any prescription or non-prescription drugs to sleep, wake or relieve pain? .... Y N

Do you consume caffeine in excess of three 8-ounce servings a day? .... Y N

Do you feel you are addicted to any sugar? .... Y N

Allergies, Food Sensitivities, and Other Chronic Inflammatory Conditions:

Are you aware of any chronic inflammatory conditions such as irritable bowel syndrome, fibromyalgia, arthritis, chronic fatigue syndrome, insulin resistance, or periodontal/gum disease?...Y N

If so, please list

Are you aware of any allergies? ....Y N

If so, please list

Oral Cancer:

Do you smoke or chew tobacco? ....Y N

Do you have any persistent sore spots in your mouth or lumps/bumps in your head or neck? ....Y N

Do you feel as if you have a lump in your throat? ......Y N

Pre Diabetes and Diabetes:

Have you ever been diagnosed with prediabetes or diabetes? .... Y N

Do you take medications for diabetes, hypertension or high cholesterol?............................. Y N

Are you more than 10% above your ideal body weight or have a waist circumference over 35” for women, or 40” for men? .... Y N

Do you have any biologic family members with diabetes? .... Y N

Do your gums bleed when you brush or floss? .... Y N

Food / Drink / Exercise:

Do you follow a special diet? ....Y N

Do you aspire to make changes to your diet? ....Y N

Do you desire a change in weight? ....Y N

What sugary foods or drinks do you consume regularly?

List any other beverages you consume on a regular basis:

Do you have exercise goals you hope to achieve?:

MEDICAL HISTORY

Please check any of the following that apply to you:

(* indicates conditions that may contribute to Gum Disease 'Oral Health')

- ☐ Acid Reflux
- ☐ AIDS
- ☐ Alcohol Addiction
- ☐ Allergies (Seasonal)
- ☐ Anemia
- ☐ Arthritis *
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease *
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy *
- ☐ Dementia/Alzheimer
- ☐ Diabetes *
- ☐ Dizziness
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Heart Conditions *
- ☐ Heart Lesions
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Jaundice
- ☐ Jaw Joint Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse *
- ☐ Depression
- ☐ Pacemaker
- ☐ Periodontal Disease
- ☐ Phen Fen (1 month +)
- ☐ Radiation (head/neck)
- ☐ Pregnant Currently*
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Sleep Apnea
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Diseases
- ☐ Weight-loss Surgery
- ☐ Other

Do you have any of the following drug allergies?

- ☐ Aspirin
- ☐ Codeine
- ☐ Darvon
- ☐ Erythromycin
- ☐ Nitrous Oxide
- ☐ Valium
- ☐ Percodan
- ☐ Penicillin
- ☐ Local Anesthetic
- ☐ Other

Are you under a physician's care? Specifically, for what?

____

____

Are you taking any medications/supplements/ vitamins?Please list below:

____

____

____

____

Do you have a desire to reduce the amount of medication you are taking? Y/N

Is there any other medical or dental information we should know about? Y/N

Have you had your gallbladder removed? Y/N

Please list all surgeries: ____

Print Name: ____

Signature (Patient or Guardian):____Date: ______