

New Patient



501 W. Lakeway Road

Gillette, WY 82718

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

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 _____

Home Care Routine:

How often do you brush? _____

How often do you floss? _____

How often do you Waterpik? _____

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')

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

Do you have any of the following drug allergies?

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Codeine |
| <input type="checkbox"/> Darvon | <input type="checkbox"/> Erythromycin |
| <input type="checkbox"/> Nitrous Oxide | <input type="checkbox"/> Valium |
| <input type="checkbox"/> Percodan | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Other |

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

Are you taking any medications? Please list below:

Do you have a desire to reduce the amount of medication you are taking? Yes / No

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