

Dental History

Former Dentist: _____ Location: _____

Date of Last Visit: _____ Last Cleaning: _____ Last X-Rays: _____

Reason for today's visit: _____

How often do you brush: _____ How often do you floss? _____

What type of toothbrush do you use? Soft Medium Hard Electric

Are you nervous about dental treatment? YES NO Please Explain: _____

Do any of the following apply to you? Place an **X** in the appropriate box for a "Yes" response. A blank box will be considered a "No" response.

Present Conditions:

- | | |
|--|--|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Dry Mouth |
| <input type="checkbox"/> Bleeding/Painful Gums | <input type="checkbox"/> Food Between Teeth |
| <input type="checkbox"/> Broken Fillings/Teeth | <input type="checkbox"/> Jaw Pain |
| <input type="checkbox"/> Changes in Bite | <input type="checkbox"/> Loose Teeth |
| <input type="checkbox"/> Cheek/Lip Biting | <input type="checkbox"/> Sensitivity to hot/cold |
| <input type="checkbox"/> Clenching/Grinding Teeth | <input type="checkbox"/> Sensitivity to sweet/sour |
| <input type="checkbox"/> Difficulty Opening Mouth | <input type="checkbox"/> Sensitivity to chewing |
| <input type="checkbox"/> Sores or Growths in Mouth | <input type="checkbox"/> Smoke/Chew Tobacco |

Past Treatment:

- Oral Surgery (extractions)
- Orthodontics (braces)
- Periodontal Treatment (gums)
- TMJ Treatment (jaw)

Dr's Notes: _____

Consent for Services

I hereby authorize Dr. Higgins and/or staff to take x-rays, models, photographs and other diagnostic aids deemed appropriate by Dr. Higgins to make a thorough diagnosis of my/ my child's dental needs. Upon such diagnosis, I authorize Dr. Higgins to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Further, I understand and acknowledge that photographs and images of me may be shown to other patients, potential patients and doctors for treatment and educational purposes and I agree to the same.

Signature of Patient or Parent: _____ Date _____

Medical History

My current physical health is: Good Fair Poor

Are you currently under the care of a physician: Yes No If Yes, Why? _____

Physician's Name: _____ Last Visit: _____ Phone: _____

Are you currently taking any over-the-counter or prescription medications: Yes No

If Yes, please list: _____

Have you ever had an adverse or allergic reaction to any drugs: Yes No

If Yes, please list: _____

Have you ever pre-medicated with antibiotics *Prior* to a dental appointment? Yes No

For Women: Are you pregnant? Yes No If yes, when is your due date? _____

Are you nursing? Yes No Taking birth control pills? Yes No

Do you have a past or present history of any of the following medical problems?

Place an "X" in the box for a "Yes" response. A blank box will be considered a "No" response.

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Cortisone Treatment | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatic/Scarlet Fever |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Smoke/Chew Tobacco |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Latex Sensitivity | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nervous/Anxious | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cancer/Chemotherapy | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Radiation Treatment | _____ |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Respiratory Disease | _____ |

I certify that I have read and understood the contents of this form. All of the preceding answers and information provided are true and correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. If I ever have any change in my health, I agree to inform Dr. Higgins at the next appointment without fail.

Signature of Patient or Parent: _____ Date ____ / ____ / ____

New Patient Questionnaire

Please help us to get to know you by completing the following form so that we may provide you with a customized treatment plan that reflects your goals. For multiple choice questions, please check all answers that apply.

Name: _____ Age: _____ Date: ____/____/____

1. What are your hobbies?

2. Family Members and ages? _____

3. What goals are you hoping to achieve with your dental treatment? _____

Improve appearance of teeth/smile. Explain: _____

Improve function. Explain: _____

Improve overall dental health and prevent tooth loss.

None – I'm only interested in maintenance through regular check-ups and cleanings.

4. Which of the following best describes your attitude toward dental care?

Proactive: I want to minimize my chance of dental emergencies by treating potential problems now.

Reactive: I would rather leave my teeth alone and only fix a problem if and when I have one.

5. Have you ever had a dental emergency? YES NO

If Yes, please describe: _____

6. Are you interested in any cosmetic dental services? YES NO

If YES, please check all that apply:

Teeth Whitening (bleaching)

Replacement of unattractive silver fillings or crowns

Porcelain veneers or crowns

Orthodontics (braces) to correct misaligned teeth

7. Do you have any missing teeth that are in need of replacement? YES NO

If YES, are you interested in replacement with:

Fixed restorations such as dental implants or bridges

Removable appliances such as partial dentures

8. Have you neglected your dental health over the past few years? YES NO

If yes, because of: Finances Time Fear/Pain Procrastination

9. Why did you leave the dental office that treated you previously? _____