Dental Arts *of* Tellico Village

Welcome

Patient Number

Age ______ Today's Date ______

Patient Information

Last Name ______ First Name ______ Initial ______

Date of Birth ______ ☐ Male ☐Female If child: parent's name ______

How do you wish to be addressed? ______

☐Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐Minor

Home Address Line 1 ______ Line 2 ______

City ______ State ______ Zip ______

Work Address Line 1 ______ Line 2 ______

City ______ State ______ Zip ______

Home Phone ______ Work Phone ______

Fax ______ Cell Phone ______

Email ______

Patient / Parent Employed By ______

Present Position ______ How long held ______

Spouse / Parent Name ______

Present Position ______ How long held ______

Responsible Party ______ Drivers License Number ______

Method of Payment: ☐ Insurance ☐Cash ☐Credit Card

Purpose of Call ______

Other Family Members in this Practice ______

Whom may we thank for this referral? ______

Patient SS# ______ Spouse / Parent SS# ______

Someone to notify in case of emergency not living with you ______

Dental Insurance 1st Coverage

Employee Name ______ DOB ______

Relationship to Patient ______

Employer Name ______ Years ______

Insurance Company ______

Address ______

______

Telephone ______

Program / Policy # ______

SS# ______

Union Local or Group ______

Dental Insurance 2nd Coverage

Employee Name ______ DOB ______

Relationship to Patient ______

Employer Name ______ Years ______

Insurance Company ______

Address ______

______

Telephone ______

Program / Policy # ______

SS# ______

Union Local or Group ______

Dental Arts *of* Tellico Village

Consent

Patient Number

I,_________________________________ , consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

____

____

____

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payer.

I attest to the accuracy of the information on this page.

_________________________________ _________________

Patient or Guardian's Signature Date

Dental Arts *of* Tellico Village

Dental History

Patient Number

Name ______ Nickname ______ Referred By ______

Age ______ 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 the most recent dental exam ______ Date of the most recent dental X-rays ______

Date of most recent treatment (other than cleaning) ______ Purpose ______

I routinely see my dentist every: ☐3 mo. ☐4 mo. ☐6 mo. ☐12 mo. ☐Not routinely

What is your immediate concern? ______

Personal History

	Question	Yes	No
1.	Are you fearful of dental treatment? How fearful, on a scale from 1 (least) to 10 (most)? ______	☐	☐
2.	Have you 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, and at what age? ______	☐	☐
6.	Have you had any teeth removed or missing teeth that never developed or lost teeth due to injury or facial trauma?	☐	☐

Gum and Bone

	Question	Yes	No
7.	Do your gums bleed or are they painful when brushing or flossing?	☐	☐
8.	Have you ever been treated for gum disease or been told you have lost bone around your teeth?	☐	☐
9.	Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐
10.	Is there anyone with a history of periodontal disease in your family?	☐	☐
11.	Have you ever experienced gum recession?	☐	☐
12.	Have you ever had any teeth become loose on their own (without injury), or do you have difficulty eating an apple?	☐	☐
13.	Have you experienced a burning or painful sensation in your mouth not related to your teeth?	☐	☐

Tooth Structure

	Question	Yes	No
14.	Have you had any cavities within the past 3 years?	☐	☐
15.	Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	☐	☐
16.	Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	☐	☐
17.	Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	☐	☐
18.	Do you have grooves or notches in your teeth near the gum line?	☐	☐
19.	Have you ever broken teeth, chipped teeth, or had any toothache or cracked filling?	☐	☐
20.	Do you frequently get food caught between any teeth?	☐	☐

Bite and Jaw Joint

	Question	Yes	No
21.	Do you have any problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐	☐
22.	Do you feel like your lower jaw is being pushed back when you bite your teeth together?	☐	☐
23.	Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐	☐
24.	In the past 5 years, have your teeth changed (became shorter, thinner, or worn) or has your bite changed?	☐	☐
25.	Are your teeth becoming more crooked, crowded, or overlapped?	☐	☐
26.	Are your teeth developing spaces or becoming more loose?	☐	☐
27.	Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?	☐	☐
28.	Do you place your tongue between your teeth or close your teeth against your tongue?	☐	☐
29.	Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐	☐
30.	Do you clench your teeth in the daytime or make them sore?	☐	☐
31.	Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?	☐	☐
32.	Do you wear or have you ever worn a bite appliance?	☐	☐

Smile Characteristics

	Question	Yes	No
33.	Is there anything about the appearance of your teeth that you would like to change (shape, color, size)?	☐	☐
34.	Have you ever whitened (bleached) your teeth?	☐	☐
35.	Have you felt uncomfortable or self conscious about the appearance of your teeth?	☐	☐
36.	Have you been disappointed with the appearance of previous dental work?	☐	☐

Patient Signature ______ Date ______

Doctor Signature ______ Date ______

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Dental Arts *of* Tellico Village

Medical History

☐☐☐☐☐☐
Patient Number

Name ______________ Nickname ______________ Age ________

Name of Physician/and their specialty ______________________________

Date of your most recent physical exam ______________ Purpose ______________

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have or have you ever had:

	Yes	No
1. hospitalization for illness or injury	☐	☐
2. an allergy or bad reaction to any of the following	☐	☐
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfa		
☐ local anesthetic		
☐ fluoride		
☐ metals (nickel, gold silver,_______)		
☐ latex		
☐ nuts ______________		
☐ fruit ______________		
☐ other ______________		
3. heart problems, or cardiac stent within the last six months	☐	☐
4. history of infective endocarditis	☐	☐
5. artificial heart valve, repaired heart defect (PFO)	☐	☐
6. pacemaker or implantable defibrillator	☐	☐
7. orthopedic implant (joint replacement)	☐	☐
8. rheumatic or scarlet fever	☐	☐
9. high or low blood pressure	☐	☐
10. a stroke (taking blood thinners)	☐	☐
11. anemia or other blood disorder	☐	☐
12. prolonged bleeding due to a slight cut (INR > 3.5)	☐	☐
13. pneumonia, emphysema, shortness of breath, sarcoidosis	☐	☐
14. tuberculosis, measles, chicken pox	☐	☐
15. asthma	☐	☐
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)	☐	☐
17. kidney disease	☐	☐
18. liver disease	☐	☐
19. jaundice	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency	☐	☐
21. hormone deficiency	☐	☐
22. high cholesterol or taking statin drugs	☐	☐
23. diabetes (HbA1c=_______)	☐	☐
24. stomach or duodenal ulcer	☐	☐
25. digestive or eating disorders (i.e. celiac disease, gastric reflux, bulimia, anorexia)	☐	☐
26. osteoporosis/osteopenia (i.e. taking bisphosphonates)	☐	☐
27. arthritis	☐	☐
28. autoimmune disease (i.e. rheumatoid arthritis, lupus, scleroderma)	☐	☐
29. glaucoma	☐	☐
30. contact lenses	☐	☐
31. head or neck injuries	☐	☐
32. epilepsy, convulsions (seizures)	☐	☐
33. neurological disorders (ADD/ADHD, prion disease)	☐	☐
34. viral infections and cold sores	☐	☐
35. any lumps or swelling in the mouth	☐	☐
36. hives, skin rash, hay fever	☐	☐
37. STI / STD / HPV	☐	☐
38. hepatitis (type _______)	☐	☐
39. HIV / AIDS	☐	☐
40. tumor, abnormal growth	☐	☐
41. radiation therapy	☐	☐
42. chemotherapy, immunosuppressive medication	☐	☐
43. emotional difficulties	☐	☐
44. psychiatric treatment	☐	☐
45. antidepressant medication	☐	☐
46. alcohol / recreational drug use	☐	☐

Are You:

	Yes	No
47. presently being treated for any other illness	☐	☐
48. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea)	☐	☐
49. taking medication for weight management	☐	☐
50. taking dietary supplements	☐	☐
51. often exhausted or fatigued	☐	☐
52. experiencing frequent headaches	☐	☐
53. a smoker, smoked previously, or use smokeless tobacco	☐	☐
54. considered a touchy / sensitive person	☐	☐
55. often unhappy or depressed	☐	☐
56. taking birth control pills	☐	☐
57. currently pregnant	☐	☐
58. having prostate disorders	☐	☐

Describe any current medical treatment, impending surgery, genetic/developmental delay , or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

____

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGES IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient Signature ______________________ Date ______________

Doctor Signature ______________________ Date ______________

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