PATIENT INFORMATION

Welcome to OrthoGrace Dental. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following forms. The information provided on this form is important to your dental health. If there are any changes in your health at any time, please tell us, and if you have any questions please do not hesitate to ask.

Today's Date:_______________

Patient name:_______________ Date of birth:_______________ Age:_______ Sex: _______

Home address:_______________ City: _______________ ST:_______ Zip:_______

Billing address (if different):_______________ City:_______________ ST:_______ Zip:_______

Home Phone:_______________ Work:_______________ Cell:_______________ Preferred:_______

E-mail address: _______________

Can we add you to our e-mail list: YES / NO Can we text you (appointment reminders, etc.): YES / NO

SS#:_______________ Employer / Occupation:_______________

Emergency Contact (and relationship):_______________ Phone:_______________

Dental Insurance (circle one): YES / NO If yes, Carrier:_______________ Are you the subscriber: YES/NO

Name of your medical doctor:_______________ Date of last visit:_______________

Name of your previous dentist:_______________ Date of last visit:_______________

Referred to us by: _______________

DENTAL HEALTH HISTORY

	Yes	No
Are you apprehensive about dental treatment?	[ ]	[ ]
Have you had problems with previous dental treatment?	[ ]	[ ]
Do you gag easily?	[ ]	[ ]
Do you wear dentures?	[ ]	[ ]
Does food catch between your teeth?	[ ]	[ ]
Do you have difficulty in chewing your food?	[ ]	[ ]
Do you chew on only one side of your mouth?	[ ]	[ ]
Do you avoid brushing any part of your mouth because of pain?	[ ]	[ ]
Do your gums bleed easily?	[ ]	[ ]
Do your gums bleed when you floss?	[ ]	[ ]
Do your gums feel swollen or tender?	[ ]	[ ]
Have you ever noticed slow-healing sores in or around your mouth?	[ ]	[ ]
Are your teeth sensitive?	[ ]	[ ]
Do you feel twinges of pain when your teeth come in contact with:		
Hot foods or liquids?	[ ]	[ ]
Cold foods or liquids?	[ ]	[ ]
Sours?	[ ]	[ ]
Sweets?	[ ]	[ ]
Do you take fluoride supplements?	[ ]	[ ]
Are you dissatisfied with the appearance of your teeth?	[ ]	[ ]
Do you prefer to save your teeth?	[ ]	[ ]

	Yes	No
Do you want complete dental care?	[ ]	[ ]
How often do you brush?		
How often do you floss?		
Does your jaw make noise so that it bothers you or others?	[ ]	[ ]
Do you clench or grind your jaw frequently?	[ ]	[ ]
Does your jaw ever feel tired?	[ ]	[ ]
Does your jaw get stuck so that you can't open freely?	[ ]	[ ]
Does it hurt when you chew or open wide to take a bite?	[ ]	[ ]
Do you have earaches or pain in front of your ears?	[ ]	[ ]
Do you have any jaw symptoms or headaches upon awaking in the morning?	[ ]	[ ]
Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities?	[ ]	[ ]
Do you find jaw pain or discomfort extremely frustrating or depressing?	[ ]	[ ]
Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)?	[ ]	[ ]
Do you have a temporomandibular (jaw) disorder (TMD)?	[ ]	[ ]
Do you have pain in the face, cheeks, jaws, joints, throat, or temples?	[ ]	[ ]
Are you unable to open your mouth as far as you want?	[ ]	[ ]
Are you aware of an uncomfortable bite?	[ ]	[ ]
Have you had a blow to the jaw (trauma)?	[ ]	[ ]
Are you a habitual gum chewer or pipe smoker?	[ ]	[ ]

MEDICAL HEALTH HISTORY

Do you have, or have you had, any of the following?

	Yes	No
Heart Problems	[ ]	[ ]
Chest pain	[ ]	[ ]
Shortness of breath	[ ]	[ ]
Blood pressure problems	[ ]	[ ]
Heart murmur	[ ]	[ ]
Heart valve problems	[ ]	[ ]
Taking heart medication	[ ]	[ ]
Rheumatic fever	[ ]	[ ]
Pacemaker	[ ]	[ ]
Artificial heart valve	[ ]	[ ]
Blood Problem	[ ]	[ ]
Easy Bruising	[ ]	[ ]
Frequent nosebleeds	[ ]	[ ]
Abnormal bleeding	[ ]	[ ]
Blood disease (anemia)	[ ]	[ ]
Ever require a blood transfusion	[ ]	[ ]
Allergy Problems	[ ]	[ ]
Hay fever	[ ]	[ ]
Sinus problems	[ ]	[ ]
Skin rashes	[ ]	[ ]
Taking allergy medication	[ ]	[ ]
Asthma	[ ]	[ ]
Intestinal Problem	[ ]	[ ]
Ulcers	[ ]	[ ]
Weight gain or loss	[ ]	[ ]
Special Diet	[ ]	[ ]
Constipation/Diarrhea	[ ]	[ ]
Kidney or bladder problems	[ ]	[ ]
Bone or joint problems	[ ]	[ ]
Arthritis	[ ]	[ ]
Back or neck pain	[ ]	[ ]
Joint replacement	[ ]	[ ]
Fainting spells, seizures, epilepsy?	[ ]	[ ]
Stroke(s)	[ ]	[ ]
Frequent or severe headaches	[ ]	[ ]
Thyroid problems	[ ]	[ ]
Persistent cough or swollen glands	[ ]	[ ]
Cancer/Tumor	[ ]	[ ]
Pre medications required by physician	[ ]	[ ]

If so, what are they?____

Are you allergic, or have you reacted adversely, to any of the following?	**Yes**	**No**
Local anesthetics (Novocain)	[ ]	[ ]
Penicillin or other antibiotics	[ ]	[ ]
Sulfa Drugs	[ ]	[ ]
Barbiturates, sedatives or sleeping pills	[ ]	[ ]
Aspirin, Acetaminophen, or Ibuprofen	[ ]	[ ]
Codeine, Demerol, or other narcotics	[ ]	[ ]
Reaction to meds	[ ]	[ ]
Latex or Rubber Dam	[ ]	[ ]

Other____

Notes:____

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	Yes	No
Diabetes	[ ]	[ ]
Urinate more than 6 times a day	[ ]	[ ]
Thirsty or dry mouth most of the time	[ ]	[ ]
Family history of diabetes	[ ]	[ ]
Osteoporosis	[ ]	[ ]
Tuberculosis or other respiratory disease	[ ]	[ ]
Do you drink Alcohol?	[ ]	[ ]

If so, how much?____

	Yes	No
Do you Smoke?	[ ]	[ ]

If so, how much?____

	Yes	No
Hepatitis, jaundice, or liver trouble	[ ]	[ ]
Herpes or other STD	[ ]	[ ]
HIV-positive/AIDS	[ ]	[ ]
Glaucoma	[ ]	[ ]
Do you wear contact lenses?	[ ]	[ ]
History of head injury	[ ]	[ ]
History of alcohol or drug abuse	[ ]	[ ]

Do you have any diseases, condition, or problem not listed previously that you feel we should know about? If so, please describe:

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During the past 12 months, have you taken any of the following?	**Yes**	**No**
Bisphosphonates (e.g. Fosamax)	[ ]	[ ]
Antibiotics or sulfa drug	[ ]	[ ]
Anticoagulants (e.g.coumadin)	[ ]	[ ]
High blood pressure medicine	[ ]	[ ]
Tranquilizers	[ ]	[ ]
Insulin, Orinase, or Similar drug	[ ]	[ ]
Aspirin	[ ]	[ ]
Digitalis or drugs for heart trouble	[ ]	[ ]
Nitroglycerin	[ ]	[ ]
Cortisone (steroids)	[ ]	[ ]
Natural remedies	[ ]	[ ]
Nonprescription drug/supplements	[ ]	[ ]

Other:____

Women	**Yes**	**No**
Are you taking contraceptives or other hormones?	[ ]	[ ]
Are you pregnant?	[ ]	[ ]

If so, expected delivery date (or last ms) _________________________

	Yes	No
Are you nursing?	[ ]	[ ]
Have you reached Menopause?	[ ]	[ ]

If so, do you have any symptoms?____________________________

Patient signature: ____________________________________

Parent signature: ____________________________________
(if patient is a minor)

Dentist Initial: _______