PATIENT INFORMATION FORM

Name:_____ Nickname: _____

Address: _____
Street City / State Zip Code

Employer_____ Occupation _____

Home Ph.#_____ Work Ph.#_____ Fax.#_____

Cell Ph.#_____Pager #_____

SS#_____ Birthdate_____ Drivers Lic: _____

Spouse's Name_____ Employed by:_____

Whom may we thank for referring you to our office?_____

PERSON RESPONSIBLE FOR PAYMENT

Name_____ Relationship to patient _____

Address: _____
Street City / State Zip Code

Employer_____ Occupation _____

Home Ph.#_____ Work Ph.#_____ Fax.#_____

SS#_____ Birthdate_____

DENTAL INSURANCE INFORMATION

Primary Insurance Company_____Group # _____

Insured's Name_____SS#_____ DOB _____

DENTAL HISTORY

Do you have a dental complaint at this time? _____

What was the date of your last dental treatment? _____

How often did you see your dentist? _____

Have you ever had an unpleasant dental experience? _____

Who was your last dentist and where? _____

Do you grind or clench your teeth? Yes No

Do you have pain in your jaw joint? Yes No

Do you have sore or sensitive teeth? Yes No

Do your gums bleed? Yes No

Do you get cold or canker sores? Yes No

Do you have an unpleasant taste in your mouth? Yes No

Do you have frequent headaches? Yes No

Do you have ear aches? Yes No

How often do you brush your teeth? _____

How often do you floss your teeth? _____

Do you have any: Loose____ Cracked____ Broken teeth____? Check all that apply

Have you had periodontal treatment? _____

Have you ever worn braces? _____ When? _____Dr's name: _____

Do you have any missing teeth? _____Have they been replaced? _____

If so how? Fixed bridge____ Removable partial____ Denture____ Implant ____

How do you feel about the appearance of your smile? _____

Would you be interested in whiter teeth? _____ , or cosmetic dentistry to improve your smile? ____

Name of spouse or parents _____

Work place of spouse _____phone number _____

Whom should we contact in case of an emergency? _____

Who may we thank for referring you to our office? _____

MEDICAL HISTORY

PATIENT NAME_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ○ Yes ○ No ○ N/A _____

Have you ever been hospitallized or had a major operation? ○ Yes ○ No ○ N/A _____

Have you ever had a serious head or neck injury? ○ Yes ○ No ○ N/A _____

Are you taking any medications, pills, or drugs? ○ Yes ○ No ○ N/A _____

Do you take, or have you taken, Phen-Fen or Redux ? ○ Yes ○ No ○ N/A Do you use tobacco? ○Yes ○ No ○ N/A

Are you on a special diet? ○ Yes ○ No ○ N/A Do you use controlled substances? ○Yes ○ No ○ N/A

Women: Are you ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptive?

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other_____

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

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur*	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve*	☐ Drug Addiction	☐ Heart Pace Maker*	☐ Mitral Valve Prolapse*	☐ Stroke
☐ Artificial Joint*	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever*	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ○ Yes ○ No ○ N/A _____

Comments: _____

_____

_____

*Condition may require medication N/A - Not answered by patient

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN DATE

PATIENT QUESTIONNAIRE

I. PERSONAL INFORMATION

Name:_____Telephone # Home:_____Work:_____
Address:_____
Occupation:_____
Date of Birth:_____Age:____,Sex:_____, Race:_____, Height ___'___", Weight_____
Marital Status:( ) Married, ( ) Remarried, ( ) Single, ( ) Divorced, ( ) Separated, ( )Widowed
With whom do you live? (Please name people living at home)
Name(s):_____ Relation_____; Name(s): _____ Relation_____
Name(s): _____ Relation_____; Name(s): _____ Relation_____
Name(s): _____ Relation_____; Name(s): _____ Relation_____
Name(s): _____ Relation_____; Name(s): _____ Relation_____

Check the highest grade of schooling you have completed?
( ) less than high school ( ) high school ( ) vocational technical
( ) vocational business ( ) college ( ) graduate or professional
( ) other (describe): _____

Please list the name, sex and age of your children: _____
_____

Are you involved in a lawsuit concerning your pain? . . . YES NO
Who referred you to us? Name:_____, Phone # _____
Address:_____
Whom do you regard as your primary doctor?_____
Who is your dentist? _____

II. CHIEF COMPLAINTS

Please write the reason(s) you are here. Begin with the worst one.
1._____ How long have you had this problem?_____

2._____How long have you had this problem?_____

3._____How long have you had this problem?_____

4._____How long have you had this problem?_____

5._____How long have you had this problem?_____

III. INFORMATION ABOUT YOUR PAIN

1. Please describe what event or events lead to your pain:

_____

_____

_____

2. Please indicate what you think is the cause of your pain.

_____

_____

3. How often does your pain occur?

___ Continuously (nonstop)
___ Several time a week
___ once or twice a month
___once or twice a day
___ several times a day
___less than 3-4 times per months
___less than one a month

4. How has the intensity of the pain changed throughout the time you have had it?
_____increased _____decreased _____ stayed the same

5. If you have pain-free periods, how long do they last?
_____minutes, _____hours, _____days, _____weeks, _____months

6. Describe the circumstances of your last pain-free period of 3 or more days, if you had one:_____

_____

7. Which of the following affect your pain?

Mark "B" for better, "W" for worse, and leave blank for "no effect".

___heat	___cold	___sitting	___massage or rubbing
___walking	___ running	___standing	___lying down
___coughing	___fatigue	___straining	___getting out of bed
___vibration	___anxiety	___noise	___sudden movements
___wet climate	___hot climate	___cold climate	___alcoholic drinks
___caffeinated drinks (coffee, tea, colas)			___work

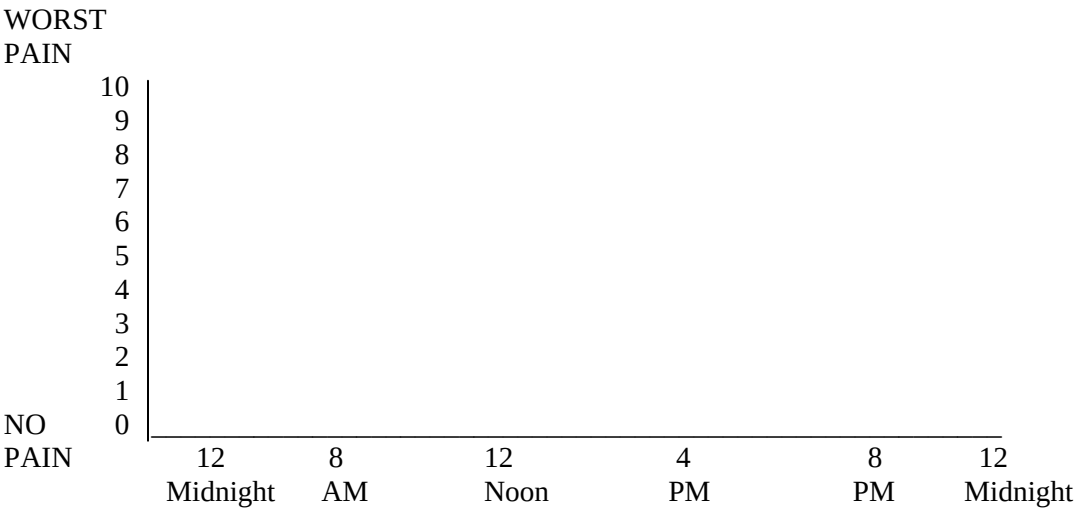
___strong emotion (anger, excitement, surprise, etc.)
___ other _____
___ particular movements (explain)_____

8. The following scale represents pains of increasing intensity. Would you please mark on the scale the intensity of your pain right now by placing an "N", the intensity of your pain at its worst by placing a "W", and the intensity of your pain at it s lease by placing an "L".

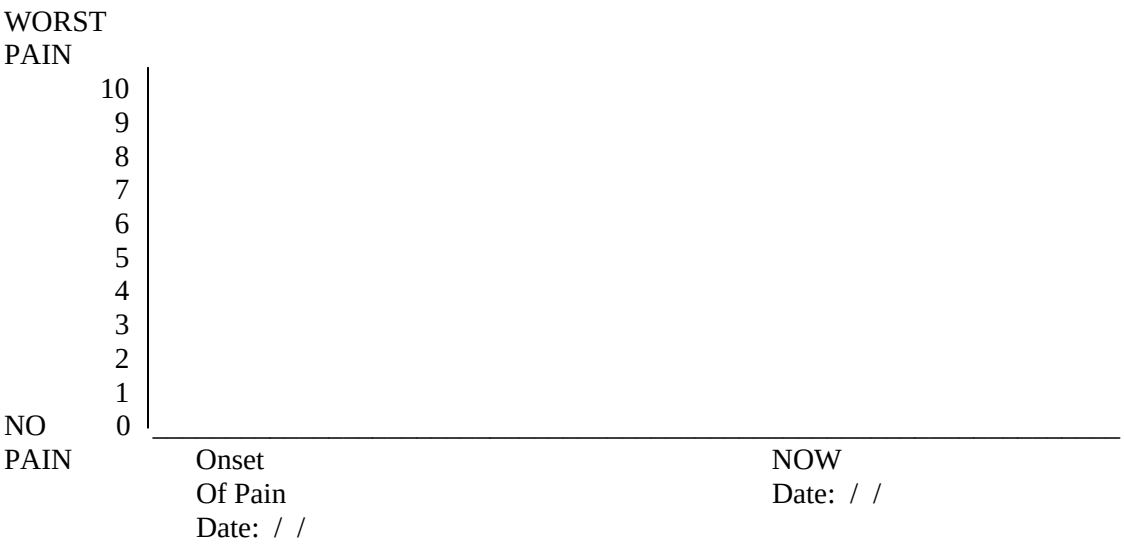
No Pain _____ The worst pain ever

Percentage of time

9. Please draw a line on the graph below to show us how **YOUR** pain changes through the day. If it does not change, draw a straight line at the approximate pain level.



10. Please draw a line on the graph below to show us how **YOUR** pain changes through the entire period of time since it began.



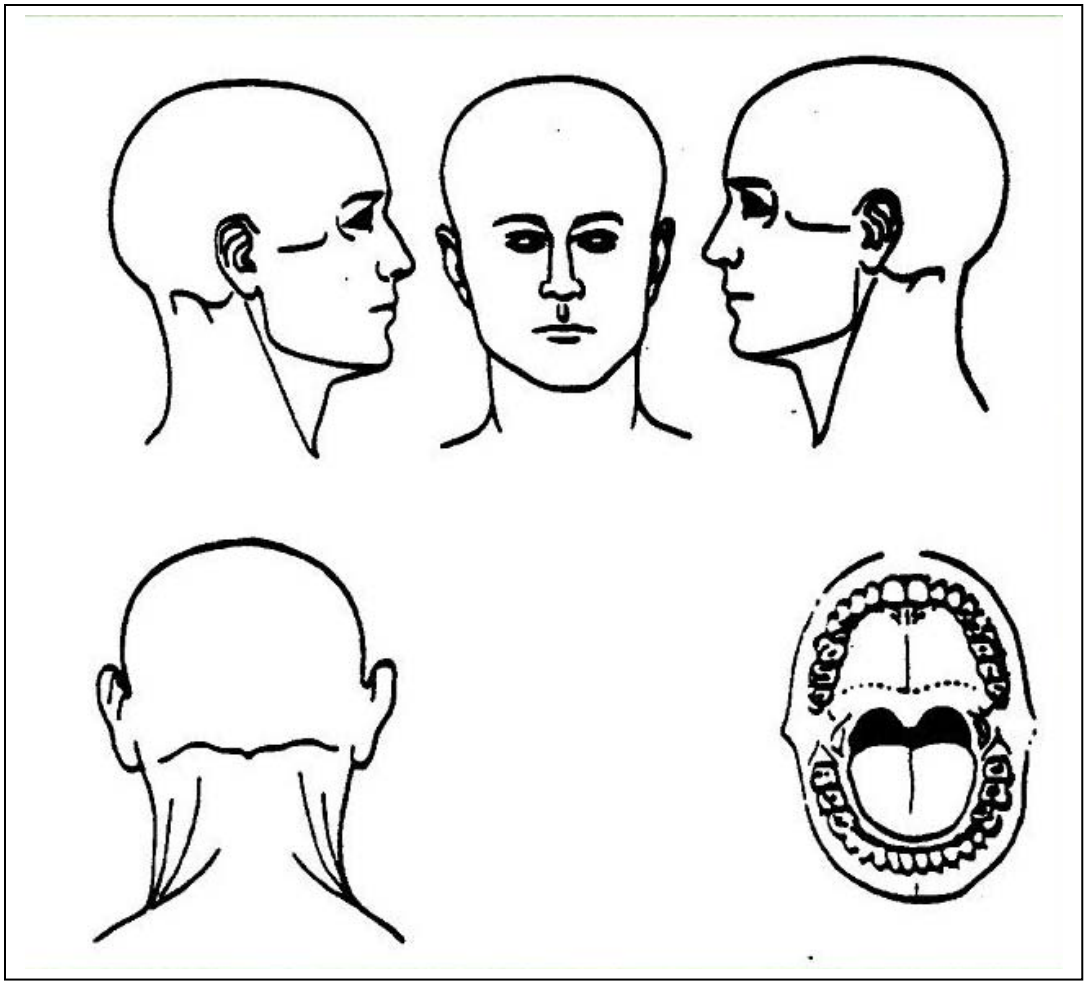
11. Please list all the medications that you are taking now.

Drug	*Strength*	*# pills per day*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

12. LOCATION OF YOUR PAIN

- Using these pictures, indicate which parts of your head and neck are affected by pain by shading them with a pen or a pencil.
- If you have more than one type of pain, you may use a different color for each.
- If you have any particularly sensitive areas or trigger points, label them with an "X".
- If you have pains in other areas of your body that are not in these pictures, please list them here: _____

  _____



13. QUALITY OF THE PAIN

A. In your own words, describe what your pain feels like.

_____

_____

B. Some of the words below may describe your present pain. **Circle only one in each of the 20 groups, if the group contains a word that describes your pain. <u>Leave out any group that is not suitable.</u>**

1	2	3	4
Flickering	Jumping	Pricking	Sharp
Quivering	Flashing	Boring	Cutting
Pulsing	Shooting	Drilling	Lacerating
Throbbing	Shocking	Stabbing	
Beating		Lancinating	
Pounding			

5	6	7	8
Pinching	Tugging	Hot	Tingling
Pressing	Pulling	Burning	Itchy
Gnawing	Wrenching	Scalding	Smarting
Cramping		Searing	Stinging
Crushing			

9	10	11	12
Dull	Tender	Tiring	Sickening
Sore	Taut	Exhausting	Suffocating
Hurting	Rasping		
Aching	Splitting		
Heavy			

13	14	15	16
Fearful	Punishing	Wretched	Annoying
Frightful	Grueling	Blinding	Troublesome
Terrifying	Cruel		Miserable
	Vicious		Intense
	Killing		Unbearable

17	18	19	20
Spreading	Tight	Cool	Nagging
Radiating	Numb	Cold	Nauseating
Penetrating	Drawing	Freezing	Agonizing
Piercing	Squeezing	Icy	Dreadful
	Tearing		Torturing

14. EFFECT OF PAIN ON ACTIVITY

Please describe how your pain interferes with your daily activities at work or at home.

_____

_____

15. ***EFFECT OF PAIN ON SLEEP***

A. Do you have trouble going to sleep?_____
B. Do you have trouble staying asleep?_____

IV. PAST MEDICAL HISTORY

1. What other medical problem do you have now?

_____

_____

_____

2. Please list all operations and hospitalizations you have had and the dates (include tonsillectomy, appendectomy and hysterectomy, if applicable).

_____

_____

_____

3. Have you ever had or do you currently have any of the following?

_____diabetes _____ epilepsy _____heart disease
_____ liver disease _____kidney disease _____ulcers
_____stroke _____cancer _____joint problems
_____significant emotional problems

4. Are you sensitive or allergic (develop a rash or problem breathing or any significant problem) to any of the following?

_____penicillin _____aspirin _____codeine

_____novacaine _____sleeping pills _____iodine

_____other (please list)_____

5. Do you smoke? YES / NO If YES, how much _____

6. Please indicate the number of cups/glasses/cans you drink of the following each day.

coffee _____, tea _____, cola _____

7. Do you drink alcohol? YES / NO If YES, how much per day? _____.

V. YOUR MOOD & FUNCTIONING

For each item circle the number which best fits how you feel.

1	2	3	4
Strongly agree	Agree somewhat	Disagree somewhat	strongly disagree

1.	I worry a lot.	1 2 3 4
2.	I feel hopeful about the future	1 2 3 4
3.	I'm frequently irritable.	1 2 3 4
4.	I enjoy doing things as much as ever	1 2 3 4
5.	I sleep as well as ever	1 2 3 4
6.	I often feel depressed	1 2 3 4
7.	I often feel nervous or fearful	1 2 3 4
8.	I have lots of energy	1 2 3 4
9.	My memory and concentration seem fine	1 2 3 4
10.	My appetite has changed	1 2 3 4
11.	My weight has not changed much over the past couple of months	1 2 3 4
12.	I feel like I have little control over much of what happens to me	1 2 3 4
13.	I have much to be angry about	1 2 3 4
14.	I don't feel like doing many of the things I used to enjoy	1 2 3 4
15.	I often feel guilty	1 2 3 4
16.	I feel like there are people in my life I can truly count on for support	1 2 3 4
17.	I'm under a lot of stress at this time	1 2 3 4
18.	I feel I'm lucky in life	1 2 3 4

VI. SOME DENTAL QUESTIONS

1. Have you ever had any trauma to the head or neck? YES / NO
   If yes, please give the year and some detail about the trauma:

   _____

   _____

   _____

2. Have you ever had any occlusal splints (bite planes, night guards, etc.)? YES / NO

3. Have you ever had any "occlusal equilibration" of the teeth? YES / NO
   (Grinding on the enamel to make the teeth fit better).

4. Have you ever had any orthodontic treatment? YES / NO
   (Straightening the teeth with braces or removable appliances)

5. Do you keep your teeth together most or all of the time? YES / NO
   (Do you clench or grind your teeth together?) DAY / NIGHT

6. On which side do you chew your food? RIGHT / LEFT / BOTH

VII. FINALLY !

1. Is there any information not requested on this questionnaire that you think might be important or relevant to your case? If so, please use this space to give us your thoughts.

_____

_____

_____

_____

_____

2. RELEASE OF INFORMATION

May we release this information on this questionnaire to the referring dentist or physician and other doctors participating in your care? YES / NO
If YES, please sign and date:

Signature:_____

Date:_____