Drs. Neumeister & Heydinger

Name ______________________________ Date of Birth ____________ Date Today ____________

DENTAL INFORMATION

Privacy: All information sought with this form is confidential and private and asked with the intention of giving you the best possible care. The following questions are meant to enable you to express your feelings about dentistry and being a patient so that we may serve you to the best of our abilities. I feel that happens best when I understand as much as I can about you as a person.

Whom may I thank for referring you to my office? ______________________________

Name of previous dentist: ______________________________

I will contact him/her for any past records that would help in treatment continuity unless you specify that I should not. There may be some saving in not having to duplicate a previously performed service.

Are there any special reasons why you are seeking dental treatment at this time? YES NO

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Do you have any concerns about your teeth? YES NO

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What concerns do you have about being a patient at Dental Health?

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What are your expectations of me and my staff?

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What, if anything, in the past has kept you from having the dental treatment you needed?

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Would you be very disturbed if you had to lose your teeth and wear false teeth at some time during your life? YES NO

Do you feel that you presently have a large number of dental problems that need correction? YES NO

Do you have a great deal of fear about having your teeth worked on? YES NO

Do you feel that the amount of care you are giving your teeth will be sufficient to allow you to keep your teeth all your lifetime? YES NO

Any additional things you would like us to know so we can be more helpful to you?

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Please circle appropriate answer:

Do you presently have tooth pain because of heat, cold or sweets when chewing? YES NO

Does food frequently catch between your teeth? YES NO

Do you frequently break or lose fillings? YES NO

Have you had or been told you have gum disease? YES NO

Do you frequently snack during the day? YES NO

If so, what foods ______________________________

Have any of your teeth shifted position in the last five years? YES NO

Do you chew on both sides of your mouth? YES NO

If not, why not? ______________________________

Did you know that black tartar forms under the gums when they bleed? YES NO

Did you know that extensive destruction of the bone under the gum can take place before the patient is aware of it? YES NO

Do your gums bleed when you chew or brush you teeth? YES NO

Do you understand the meaning of "traumatic occlusion?" YES NO

Are you concerned about mouth odors or bad breath? YES NO

Are you aware that you do have it? YES NO

How often do you have your teeth cleaned?

- ☐ Several times a year
- ☐ Once a year
- ☐ Not regularly

Please check any items below that you often use in mouth care:

- ☐ hand toothbrush
- ☐ electric toothbrush
- ☐ dental floss
- ☐ gum stimulators, toothpicks Stimudents
- ☐ rubber tip
- ☐ water spray
- ☐ other ______________________________

over

OCCLUSAL EVALUATION

Do you have headaches more than 2-3 times per week? YES NO

Do you have occasional ringing in your ears? YES NO

Are you aware of clenching or grinding your teeth at any time? YES NO

Do you ever experience difficulty in opening widely or in closing your mouth? YES NO

Do you notice clicking or popping noises when you open or close? YES NO

Do you ever experience pain around your ears? YES NO

Do you ever have frequent pain in your neck or upper back (2-3 times/week)? YES NO

Do you ever wake up with a tired or aching feeling in your jaw muscles or joints? YES NO

Have you broken off a large piece of tooth or filling on more than one occasion? YES NO

HEALTH HISTORY

Are you in good health? YES NO

Date of last physical examination ______________

Name of physician ______________

Have there been any changes in health within the last year? YES NO

Are you now under the care of a physician? YES NO

If so, what is the condition being treated?

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Have you had any serious illness or operation? YES NO

If yes, explain ______________

Are you allergic to any metals? YES NO

Are you taking any medications? YES NO

if so, which ones? ______________

Are you allergic to any medications? YES NO

If so, which ones? ______________

Have you ever been told that you need to pre-medicate with an antibiotic before receiving dental treatment? ______________

Check any of the following conditions you have or have been treated for:

- ☐ Heart Trouble
- ☐ Heart Murmur
- ☐ Blood Pressure Problems
- ☐ Rheumatic Fever
- ☐ Allergy
- ☐ Asthma
- ☐ Sinus Trouble
- ☐ Headaches
- ☐ Diabetes
- ☐ Hepatitis or Jaundice
- ☐ Arthritis
- ☐ Artificial Hips or Joints
- ☐ Stomach Ulcer
- ☐ Kidney Trouble
- ☐ Thyroid Trouble
- ☐ Tuberculosis
- ☐ Epilepsy or Seizures
- ☐ Psychiatric Treatment
- ☐ Cancer or Tumor
- ☐ Radiation Therapy
- ☐ Chemotherapy
- ☐ AIDS or HIV Positive
- ☐ Frequent Bruises
- ☐ Anemia
- ☐ Stroke
- ☐ Drug Addiction

Have you had any serious trouble associated with any previous dental treatment? YES NO

If so, explain: ______________

Do you have any disease, condition or problem not listed that you think I should know about? YES NO

If so, explain: ______________

WOMEN: Are you presently pregnant or trying to become pregnant? YES NO

Are you presently taking birth control pills? YES NO

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

SIGNATURE: ______________ DATE: ______________

MEDICAL UPDATE

Date ______________

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Date ______________

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Date ______________

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Date ______________