NORTHWEST Smiles

Welcome to our practice! By filling out this form completely we can provide appropriate care with the right information.

PATIENT INFORMATION

Name_____ Nickname?_____
Last First Initial

Address_____City_____

State_____ Zip_____ Home Phone_____ Cell phone_____

E-mail _____Social Security #_____

Sex ☐M ☐F Age_____ Date of Birth _____ ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Employer_____ Occupation_____

Employer Address_____ Work Phone_____

Whom may we thank for referring you? _____

How did you hear about our office? ☐Internet Search ☐Our Website ☐Facebook ☐Twitter ☐Coach's Newsletter

Notify in case of emergency_____Home Phone _____Cell Phone_____

Dental Insurance? ☐Yes ☐No Please provide dental insurance card.

DENTAL HISTORY

(circle one)

1. My mouth is: A.) very comfortable B.) moderately comfortable C.) uncomfortable

2. I (I am) : A.) think the appearance of my mouth is excellent B.) satisfied with the appearance of my mouth
   C.) dissatisfied with the appearance of my mouth

3. I : A.) will do anything to keep my natural teeth
   B.) want to keep my teeth, but have a certain budget of time and money I am willing to spend on them
   C.) don't care whether I keep my teeth or not

4. I : A.) have set goals for my dental health with a previous dentist B.) want to set goals for my dental health
   C.) never set goals concerning my dental health

5. I : A.) have always done the best that was recommended for my dental health
   B.) have not done what dentists have recommended for my mouth
   C.) rarely go, and don't care much about having my dental work completed

6. I : A.) put dentistry for myself and my family high on my priority list
   B.) put dentistry for myself and my family low on my priority list
   C.) it's on my list but hard to find

7. I think my present state of dental health is: A.) excellent B.) good C.) poor

8. I aspire to a mouth with: A.) excellent health B.) good health C.) poor health

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Previous Dentist_____Date of most recent dental visit_____/_____/_____

I routinely see my dentist every: ____3 mo. ____4 mo. ____6 mo. ____12 mo. ____Not routinely

What is your primary concern?_____

_____

Please check **YES** or **NO** to the following**:**

	YES	NO
PERSONAL HISTORY		
1. Are you fearful of dental treatment? How fearful, on a scale of 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?	____	____
6. Have you had any teeth removed?	____	____
GUM AND BONE		
7. Do your gums bleed or are they painful when brushing or flossing?	____	____
8. Have you 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 gum disease in your family?	____	____
11. Have you ever experienced gum recession?	____	____
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	____	____
13. Have you experienced a burning sensation in your mouth?	____	____
TOOTH STRUCTURE		
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 avoid brushing any part of your mouth?	____	____
18. Do you have grooves or notches on your teeth near the gum line?	____	____
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	____	____
20. Do you frequently get food caught between any teeth?	____	____
BITE AND JAW JOINT		
21. Do you have 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. Have your teeth changed in the last 5 years, become shorter, thinner or worn?	____	____
25. Are your teeth crowding or developing spaces?	____	____
26. Do you have more than one bite and squeeze to make your teeth fit together?	____	____
27. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	____	____
28. Do you clench your teeth in the daytime or make them sore?	____	____
29. Do you have any problems with sleep or wake up with an awareness of your teeth?	____	____
30. Do you wear or have you ever worn a bite appliance?	____	____
31. Do you wear a CPAP or snore appliance?	____	____

32. Have you ever had your bite adjusted? ____ ____

	YES	NO
SMILE CHARACTERISTICS		
33. Is there anything about the appearance of your teeth that you would like to change?	____	____
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?	____	____

MEDICAL HISTORY

Physician's name_____Location _____

Date of last visit_____ Purpose of last visit_____

Women: Pregnant? ☐Yes ☐No Birth Control pills? ☐Yes ☐No Osteoporosis medication? ☐Yes ☐No

List all current medications:_____

_____

List all allergies - medications, environmental, etc._____

Please check **YES** or **NO** whether you have had any of the following:

☐Y ☐N AIDS/HIV Positive	☐Y ☐N Fainting	☐Y ☐N Mitral valve prolapse
☐Y ☐N Anaphylaxis	☐Y ☐N Gastric reflux	☐Y ☐N Pacemaker
☐Y ☐N Anemia	☐Y ☐N Headaches	☐Y ☐N Psychiatric care
☐Y ☐N Arthritis	☐Y ☐N Heart murmur	☐Y ☐N Radiation treatment
☐Y ☐N Artificial heart valves	☐Y ☐N Heart disease	☐Y ☐N Respiratory disease
☐Y ☐N Artificial joints	☐Y ☐N Hemophilia	☐Y ☐N Rheumatic/Scarlet fever
☐Y ☐N Asthma	☐Y ☐N Herpes	☐Y ☐N Sleep apnea/snoring/CPAP
☐Y ☐N Back problems	☐Y ☐N Hepatitis	☐Y ☐N Shortness of breath
☐Y ☐N Cancer	☐Y ☐N High Blood Pressure	☐Y ☐N Stroke
☐Y ☐N Chemical dependency	☐Y ☐N Jaw Pain	☐Y ☐N Thyroid disease
☐Y ☐N Chemotherapy	☐Y ☐N Kidney disease	☐Y ☐N Tobacco habit
☐Y ☐N Diabetes	☐Y ☐N Latex allergy	☐Y ☐N Tuberculosis
☐Y ☐N Epilepsy	☐Y ☐N Liver disease	☐Y ☐N Ulcer/colitis

Additional notes:_____

_____

I have completed these questions to the best of my knowledge and understand that this information will be used by Dr. Elliott to determine appropriate and safe dental care. I will inform this office of any change in my medical status. I authorize any insurance company to pay to Dr. Elliott all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I understand that I am responsible for all fees for services rendered whether or not paid for by insurance. I authorize the diagnosis of my dental health by means of radiographs, study models, digital photographs and any other diagnostic aids deemed appropriate. I also authorize the release of any diagnostic or treatment information to third-party insurance carriers/payors or other healthcare practitioners.

Signature of Patient, Parent or Guardian:

Signature:_____ Date:_____