ELEVATE
dental wellness

·Full Name:_____

·Preferred Name:_____

·Date of Birth:_____

·Male / Female:_____

·Email Address:_____

·Mailing Address:_____

_____

·Phone Number: cell - _____

work - _____

home - _____

·Preferred Method of Contact (circle preference):

Email *Cell* *Home* *Work*

·May we leave messages of a personal nature on your preferred method of contact?

Yes *No*

·How did you hear about us? - or - Whom may we thank for referring you?_____

_____

·Occupation:_____

·Employer:_____

·Employer's Address:_____

_____

·If a Student, Name of School:_____

·Emergency Contact Information:_____

_____

·SSN or DL / ID Number:_____

·Are you?:

Minor *Single* *Married* *Domestic Partner*
Separated *Divorced* *Widowed*

·Person Responsible for Payment on Account:

(please complete if someone other than self):

Name:_____

Relationship:_____

Date of Birth:_____

Mailing Address:_____

_____

Phone Number:_____

SSN or DL Number:_____

·Is this person currently a patient in our office?

Yes *No*

·Please fill out if you have dental insurance coverage:

Insurance Company Name:_____

Insurance Company Address:_____

_____

Insurance Company Phone Number:_____

Group #:_____

INSURED'S Name:_____

INSURED'S relationship to YOU:_____

INSURED'S Date of Birth:_____

INSURED'S SSN or Member #:_____

INSURED'S Employer:_____

INSURED'S Employer's Address:_____

_____

·Are you able to see an OUT OF NETWORK provider with your dental plan?

Yes *No*

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GENERAL MEDICAL QUESTIONS:

·Are you in good health at the present time?.....YES NO
·Are you currently under the care of a physician?.....YES NO

·Physician Name and Contact Number_____

·Have you been hospitalized or diagnosed with a serious illness in the past 5 years?.....YES NO
·Date of your last complete physical: _____

·Do you use or have you EVER used tobacco products (including electronic cigarettes)?.....YES NO
·If YES, what and how long?: _____

·*Women*: Are you currently taking oral contraceptives?.....YES NO
·Are you pregnant?.....YES NO
·If YES, how far along?:_____
·Are you planning a pregnancy in the near future?.....YES NO
·Are your nursing?.....YES NO
·Are you in menopause?.....YES NO

·Do you take vitamins and/or supplements?:.....YES NO
·If YES, please list type, dosage and frequency:_____
_____
_____

·Do you take prescribed medications?:.....YES NO
·If YES, please list type, dosage and frequency:_____
_____
_____

·Do you have food allergies?:.....YES NO
·If YES, please list:_____

·Please list *all* surgeries:_____
_____

·Current Height:_____
·Current Weight:_____
·Body Mass Index *(Office Use Only)*:_____
·Blood Pressure *(Office Use Only)*:_____
·Neck Circumference *(Office Use Only)*:_____

SPECIFIC MEDICAL HISTORY: Do you currently or have you ever had the following?: YES or NO

APO 3 / 4.....YES NO
Abnormal EKG.....YES NO
Abnormal Bleeding or Bruising.....YES NO
Alcohol / Drug Abuse.....YES NO
Allergies.....YES NO
Alzheimer's Disease or Family History of AD.....YES NO
Anemia / Leukemia.....YES NO
Angina Pectoris.....YES NO
Anticoagulant Therapy.....YES NO
Anxiety / Depression.....YES NO
Arthritis / Rheumatism.....YES NO
Artificial Heart Valve.....YES NO
Artificial Joints.....YES NO
Asthma .....YES NO
Autism Spectrum.....YES NO
Autoimmune Disease.....YES NO
B12 Deficiency.....YES NO
Back / Neck Problems.....YES NO
Bell's Palsy.....YES NO
Bronchitis.....YES NO
Cancer.....YES NO
Chemotherapy.....YES NO
Chest Pain.....YES NO
Chronic Ear Pain.....YES NO
Chronic Fatigue Syndrome.....YES NO
Cold Sores / Fever Blisters.....YES NO
Colitis.....YES NO
Concussion.....YES NO
Congenital Heart Defect.....YES NO
Delayed Healing from Infections.....YES NO
Diabetes or Familial History.....YES NO
Difficulty Breathing / COPD.....YES NO
Difficulty Swallowing / Lump in Throat.....YES NO
Dry Mouth.....YES NO
Eating Disorder.....YES NO
Emphysema.....YES NO
Emotional Disturbances.....YES NO
Epilepsy.....YES NO
Fainting Spells.....YES NO
Fibromyalgia.....YES NO
Frequent Fungal Infections.....YES NO
Frequent Headaches.....YES NO
Gastrointestinal Disorders.....YES NO
GERD.....YES NO
Glaucoma.....YES NO
Head Injury.....YES NO
Heartburn.....YES NO
HIV or AIDS.....YES NO
Heart Attack/Disease/Surgery or Familial History YES NO
Heart Murmur.....YES NO
Heavy Metal Toxicity.....YES NO
Hemophilia.....YES NO
Hepatitis A / B / C .....YES NO
Hormone Replacement Therapy (Men/Women)..YES NO
HPV (Men and Women).....YES NO
Hypertension / High Blood Pressure.....YES NO
Hypoglycemia.....YES NO
Immune Suppression.....YES NO
Infective Endocarditis.....YES NO
Insomnia.....YES NO
Kidney Problems.....YES NO
Liver Disease.....YES NO
Low Blood Pressure.....YES NO
Lupus.....YES NO
Mitral Valve Prolapse.....YES NO
MTHFR.....YES NO
Multiple Sclerosis.....YES NO
Oral Contraceptives.....YES NO
Osteoporosis.....YES NO
Pacemaker / Defibrillator.....YES NO
Persistent / Frequent Cough.....YES NO
Persistent / Frequent Throat Clearing.....YES NO
Persistent / Frequent Sore Throat.....YES NO
Premedication Required.....YES NO
Psychiatric Problems.....YES NO
Pulmonary Embolism.....YES NO
Radiation Therapy.....YES NO
Rapid Fatigue.....YES NO
Rheumatic Fever / Rheumatic Heart Disease.....YES NO
Ringing in the Ears / Tinnitus.....YES NO
Seizures.....YES NO
Shaky Hands / Feet.....YES NO
Shingles.....YES NO
Sickle Cell Disease.....YES NO
Sinus Problems.....YES NO
Snoring or Sleep Apnea (been told or diagnosed).YES NO
Stomach Ulcers.....YES NO
Stroke / TIA or Familial History.....YES NO
Swelling of Ankles / Feet / Hands.....YES NO
Swollen Lymph Nodes.....YES NO
Thyroid Problems.....YES NO
Tuberculosis.....YES NO
Tumors.....YES NO
Twitching of Muscles.....YES NO

ALLERGIES/ADVERSE REACTIONS: Do you or have you ever experienced an adverse reaction to the following?: YES or NO

Acetaminophen……YES NO
Aspirin……YES NO
Codeine……YES NO
Dental Anesthetics……YES NO
Erythromycin……YES NO
Ibuprofen……YES NO
Jewelry……YES NO
Latex……YES NO
Metals……YES NO
Penicillin……YES NO
Tetracycline……YES NO
Sulfa……YES NO
Other not listed_____

****

LIFESTYLE: Do you/have you….?: YES or NO

·Drink caffeinated beverages?.....YES NO
·Drink alcohol?.....YES NO
·Use recreational drugs?.....YES NO
·Use tobacco products (including e-cigarettes)?...YES NO
·Consume citrus?.....YES NO
·Drink soda?.....YES NO
·Use sugar substitutes?.....YES NO
· Do you often feel tired, sleepy or fatigued in the daytime?.....YES NO
· Do you know if you stop breathing or has anyone witnessed you stop breathing during sleep?.....YES NO
·Taken Phen/Fen?.....YES NO
·Taken bisphosphonates (Fosamax, Zometa, Aredia)? ……YES NO
·Consume grapefruit, grapefruit juice, or grapefruit extract?.....YES NO
·Chew gum?.....YES NO
·Have trouble making decisions?.....YES NO
·Have short term memory loss?.....YES NO

·I am on a special diet……YES NO
·I exercise regularly……YES NO
·I am a proactive person……YES NO
·I am committed to my health……YES NO

·My sugar consumption is (circle one): none slight moderate high

****

APPEARANCE OF YOUR TEETH and SMILE: YES or NO

·I like my smile……YES NO
·I cover my mouth when I talk or smile……YES NO
·I am pleased with the size of my teeth……YES NO
·I am pleased with the position of my teeth……YES NO
·I am pleased with the color of my teeth……YES NO
·My teeth are too spaced……YES NO
·My teeth are too crowded……YES NO
·I can see dark fillings when I smile……YES NO

·What, if anything would you change about your teeth?_____

****

How likely are you to doze off or fall asleep in the following situations? Use the following, most appropriate number:

0 = would ***never*** doze 1 = ***slight chance*** of dozing 2 = ***moderate chance*** of dozing 3 = ***high chance*** of dozing

Sitting and reading: _____
Watching TV: _____
Sitting, inactive in a public place: _____
Passenger in a car for an hour without a break: _____
Lying down to rest in the afternoon when circumstances permit: _____
Sitting and talking to someone: _____
Sitting quietly after a lunch without alcohol: _____
In a car, while stopped for a few minutes in traffic: ____

DENTAL HISTORY

·My past dental experiences have been (circle one): eventful uneventful
·On a scale of 1 – 5 my current dental health is (1 – bad, 5 – excellent): _____
·Do you have a specific problem that needs attention now?.....YES NO
·Are you nervous or do you have anxiety about coming to the dentist or receiving dental treatment?.....YES NO
·Have you had a bad experience with a dentist/dental procedure?.....YES NO

·Date of last dental checkup:_____ ·Date of last dental radiographs (x-rays):_____

·Name/location of previous dentist:_____

·How many times a day do you brush?:_____ ·Do you use a power toothbrush?.....YES NO
·How many times a week do you floss?:_____ ·Do you use a water flosser?.....YES NO

Do you/are you/have you……? YES or NO

·Use fluoridated toothpaste?.....YES NO
·Drink fluoridated water?.....YES NO
·Use mouthwash?.....YES NO
·Have or are you concerned about bad breath?...YES NO
·Had root canal therapy?.....YES NO
·Had orthodontic treatment?.....YES NO
·Wear retainers?.....YES NO
·Had your 3rd molars (wisdom teeth) removed?...YES NO
·Currently whitening or have you ever whitened your teeth?.....YES NO
·Had trauma and/or injury to mouth/face/head? ……YES NO
·Have/had a metallic taste in your mouth?.....YES NO
·Have discomfort when chewing?.....YES NO
In your teeth?.....YES NO
In your jaw?.....YES NO
·Chew your food effectively?.....YES NO
·Currently clench/grind your teeth?.....YES NO
·Clenched/ground your teeth in the past?.....YES NO
·Wear a bite/occlusal/night guard?.....YES NO
·Wear an appliance for sleep apnea?.....YES NO
·Have difficulty breathing through your nose?.....YES NO
·Had your tonsils and/or adenoids removed? ……YES NO
·Have you been diagnosed with periodontal disease? ……YES NO
·Have a parent who has/had periodontal disease? ……YES NO
·Have a spouse/partner with periodontal disease? ……YES NO

·Have a spouse/partner with HPV?.....YES NO
·Been given instruction on how to take care of your teeth and gums?.....YES NO
·Gums that bleed / feel sore when brushed or flossed?.....YES NO
·Have teeth that are shifting?.....YES NO
·Have a bite that is changing?.....YES NO
·Have you had dental treatment on your gum tissue? ……YES NO
·Have receding gums?.....YES NO
·Have teeth that are sensitive to hot / cold / acidity / sweet?.....YES NO
·Have food that packs between your teeth?.....YES NO
·Have loose teeth?.....YES NO
·Have frequent headaches?.....YES NO
How frequent?_____
Where?_____
How severe?_____
How are they relieved?_____
·Have popping or clicking in your jaw?.....YES NO
·Able to open your jaw wide without pain or limited range of motion?.....YES NO
·Have sores or lumps in / around your mouth?.....YES NO
·Bite your lips or cheeks frequently?.....YES NO
·Wear dentures or partials?.....YES NO
·Have you had difficult extractions?.....YES NO
·Concerned about the dental materials in your mouth? ……YES NO
·Interested in more natural therapies for your oral health care?.....YES NO

Patient Signature/Date_____ Dr's Signature/Date_____