

Cazenovia Dental

Date _____
Name _____ Nickname _____

What name would you like us to call you? _____ Age _____

Address _____ Zip _____ Birthdate _____

Home Phone _____ Cell _____ Person Responsible for payment _____

Occupation _____ Business Name _____ Office Phone _____

Dental Insurance Co. _____ S.S. # _____

Spouse's Name _____ Spouse's Occupation _____

How long have you lived in the area? _____ years Name of children _____ Birthdates _____

Who referred you? _____

Hobbies, Interests, Pets, Sports _____

Musical Instruments, Etc. _____

Dental Background

What is your primary reason for coming to this office?

- | | | | |
|------------------------------------|--|--|--|
| <input type="checkbox"/> Toothache | <input type="checkbox"/> Filling/ Cavity | <input type="checkbox"/> Partial | <input type="checkbox"/> Tooth sensitive to Hot/Cold |
| <input type="checkbox"/> Checkup | <input type="checkbox"/> Dentures | <input type="checkbox"/> Crowns (caps) | <input type="checkbox"/> Tooth sensitive to pressure |
| <input type="checkbox"/> Cleaning | <input type="checkbox"/> Braces | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Tooth sensitive to sweets |

Why did you leave your former dentist? _____

Concerning my teeth I am interested in:

- Comfort Appearance Function

How do you feel about dental work?

- Don't mind it Worry about it Dread it

On a scale of 1 to 10 (10 highest), what priority do you give your teeth?

1 2 3 4 5 6 7 8 9 10 (circle one)

What dental work has been suggested but never done? _____

When was the last visit? _____ years

- | | | | |
|---|------------------------------|-----------------------------|------------------|
| Does food get caught between your teeth? | <input type="checkbox"/> yes | <input type="checkbox"/> no | How often? _____ |
| Do you floss? | <input type="checkbox"/> yes | <input type="checkbox"/> no | |
| Have you had Orthodontics? | <input type="checkbox"/> yes | <input type="checkbox"/> no | |
| Do your gums bleed/ hurt? | <input type="checkbox"/> yes | <input type="checkbox"/> no | |
| Do you gag easily? | <input type="checkbox"/> yes | <input type="checkbox"/> no | |
| Do you clench or grind your teeth? | <input type="checkbox"/> yes | <input type="checkbox"/> no | |
| Do you ever have clicking, popping or discomfort in your jaw? | <input type="checkbox"/> yes | <input type="checkbox"/> no | |
| Are you happy with the appearance of your teeth? | <input type="checkbox"/> yes | <input type="checkbox"/> no | |
| Do you have any discolored teeth that bother you? | <input type="checkbox"/> yes | <input type="checkbox"/> no | |

Medical Health

General Health: Excellent Good Fair Poor

Height _____ Weight _____ Physician's Name _____

Are you taking medication now? yes no

Please list them _____

Are you allergic to: Penicillin Codeine Local Anesthetic Other _____

MEDICAL HISTORY

Please answer the following questions by placing a check (✓) in the proper blank. Answer YES if you NOW HAVE or have EVER HAD any of the following. If you are unable to answer the question, please leave the space blank.

	Y E S	N O		Y E S	N O
1. Any change in health in last year			32. Hepatitis		
2. Being treated now by a physician			33. Had series of shots or injections		
3. Emphysema			34. Smoke now		
4. Shortness of breath			35. Low/High blood pressure (circle)		
5. Major operations, hospitalization (explain at #53)			36. Glaucoma		
6. Growth or tumor			37. Acquired Immune Deficiency Syndrome (AIDS)		
7. X-Ray treatment/therapy			38. Stomach trouble; ulcers		
8. Chemotherapy			39. Regurgitate; Vomit		
9. Rheumatic fever			40. Anemia		
10. Arthritis; Rheumatism			41. Liver, Gall bladder trouble		
11. Jaundice			42. More than two drinks of alcohol per day		
12. Diabetes			43. Kidney Trouble		
13. Tuberculosis			44. Painful urination (stone)		
14. Syphilis; Gonorrhea, V.D.			45. Gland, Goiter or Thyroid		
15. Heart Attack; Stroke (circle)			46. Excessive weight gain or loss in last 6 months		
16. Heart murmur/Heart surgery _____ yr.			47. Do you bruise easily		
17. Angina, chest pain			48. Treated for nervous or mental disorders		
18. Mitral valve prolapse			49. Any part paralyzed or numb		
19. Are you on blood thinner			50. Any pin, plate, implant or other metal support for bone		
20. Any blood disease (list)			51. Condition requiring cortisone (steroid)		
			52. History of any disease within your family		
21. Epilepsy/Seizures			53. Remarks		
22. Frequent Headaches					
23. Dizziness; lightheadedness			54. Other medical problems not listed above		
24. Eye or ear trouble			55. Is there anything else we should know about your health not covered on this form?		
25. Stuffy nose; Sinus trouble			56. Would you like to speak to Dr. Fauth privately about any problem?		
26. Asthma, hayfever or allergies			WOMEN ONLY		
27. Sinus problems			57. Any pregnancies; number:		
28. Have you had a transfusion			58. Are you pregnant now; trimester		
29. Cough, hoarseness or sore throat			59. Hysterectomy; Ovariectomy		
30. Breathe through your mouth			60. Are you taking bone density meds for osteoporosis?		
31. Do you have a pacemaker					

RELEASE:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
 I authorize the release of any information concerning my health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
 I authorize release of any information concerning my health care, advice and treatment to another dentist.
 I understand that I am responsible for all costs of dental treatment.
 I authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.
 I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE _____ DATE _____