Dietary Habits

Height ____________ Weight ____________

What did you eat for breakfast today? ____________

For lunch (if appropriate)? ____________

Do you generally eat portions that are: Large ○ Average ○ Small ○

Do you use iodized salt? Yes ○ No ○

What kind of fruit do you eat? Fresh ○ Canned ○ Sugar free ○

How many bottles of soft drinks or energy drinks do you drink daily? ______

Do you eat sweets regularly? Yes ○ No ○

Do you eat sugar-coated cereal? Yes ○ No ○

Do you prefer pancakes with: Syrup ○ Honey ○ Do not eat ○

How many cups of coffee, tea or substitute do you drink daily? ______

What do you use in your coffee, tea or substitute? ____________

When do you eat between meals? Morning ○ Afternoon ○ Night ○ Rarely ○

Which supplements do you use? Multiple ○ B-complex ○ Iron ○ Calcium ○

Vitamin A ○ B ○ C ○ None ○ . Other ________ ________ ________

Dentures

Are you interested in implants to stablize your lower dentures? Yes ○ No ○

Do any members of your family, including your parents, wear dentures? Yes ○ No ○

How many dentures do you wear? ________

How many sets have you had? ________

When were your teeth extracted? ________

How long have you worn dentures? ________

Why were your teeth extracted? ____________

If you are currently having a denture problem, is it related to:

Pain ○ Discomfort ○ Appearance ○ Function ○

How did you feel about getting dentures? ____________

Do you want your last name in your dentures? Yes ○ No ○

Additional Comments

(For Doctor's use only)

I have completed this preclinical examination questionnaire to the best of my knowledge.

We will bill your insurance as a courtesy, using your signature on file. If insurance does not pay any portion within 90 days, we reserve the right to request payment in full for services from you. Ultimately, you are responsible for all charges incurred in our office.

Signature ____________________ Date ____________

Received & witnessed by ____________ Date ______ Reviewed by Dr. ____________ Date ______

Patient Questionnaire

Purpose of Visit ____________________ **Today's Date** ____________

General Information

Dr., Mr., Mrs., Miss ____________________ Birthdate ____________
Last First Middle

Guardian's name/DPOA for healthcare, if patient is a minor ____________________

Residence address ____________________
Number Street City State Zip

Home ____________ Work ____________ Cell ____________
Area code Phone Area code Phone Area code Phone

If less than one year, previous address ____________________

E-mail ____________________

Occupation ____________ Employer ____________ No. of years ______

Business address ____________________
Employer City Zip code Phone

Marital status ____________ Name of spouse ____________

Number of dependents ______ Spouse's occupation ____________

Spouse's employer ____________________
Name of employer Address

How did you hear about us? ____________________

Referred by ____________________ When ____________

Insurance Information

If you have any type of dental insurance, please complete

Name of insurance company ____________________

Name of dental plan ____________ Group number ____________

Employee ____________ Employee social security no. ____________

Patient ____________________

Relationship to employee ____________ Patient's birthdate ____________

Employer ____________________

Employer's address ____________ Employer's phone ____________
Street City Area code Phone

Has the patient had previous dental care under this plan? ____________

Does your insurance cover diagnostic services? Yes ○ No ○ Don't know ○

Does your insurance plan cover restorative treatment? Yes ○ No ○ Don't know ○

Does your insurance plan cover replacing missing teeth? Yes ○ No ○ Don't know ○

Does your insurance plan cover tooth colored fillings in back teeth? (or do they downgrade to amalgam?) Yes ○ No ○ Don't know ○

Does your insurance plan cover implants? Yes ○ No ○ Don't know ○

How do you prefer to pay for copays and balances beyond insurance coverage? *(Patient's portion due at time of service.)*

☐ Cash/Check ☐ Credit card ☐ Care credit

Medical History

Date of birth ____________

Name of physician ____________ City ____________ Phone ____________

Do you have a current medical problem? YES ◯ NO ◯ What ____________

Allergies to medications? YES ◯ NO ◯ Type of reaction ____________

Have you ever been sick from, shown an allergy to, or told not to take:

- ◯ Antibiotics
- ◯ Codeine
- ◯ Aspirin
- ◯ Novocaine (or other dental anesthetic)
- ◯ Other drugs or medicines *(please specify)* ____________

Have you ever had any of the following:

- ◯ Arthritis, sore joints
- ◯ Auto Immune Disorder
- ◯ Blood abnormalities, anemia, leukemia
- ◯ Diabetes
- ◯ Excessive bleeding
- ◯ Fainting spells, convulsions, epilepsy
- ◯ Headaches when lying down
- ◯ Heart attack
- ◯ Heart valve disorders
- ◯ Hepatitis, liver disease, jaundice
- ◯ High blood pressure
- ◯ Lung disorder (TB, asthma, emphysema)
- ◯ Nervous breakdown, psychotherapy
- ◯ Pain, pressure or tightness in chest
- ◯ Reflux disorder
- ◯ Shortness of breath
- ◯ STD (sexually transmitted disease)
- ◯ Swelling of ankles or feet
- ◯ X-ray, radiation treatments

Are you now:

- ◯ Pregnant
- ◯ On a prescribed diet
- ◯ Using thyroid medication
- ◯ Using hormones (including birth control)
- ◯ Using anticoagulents
- ◯ Using anti-seizure medication
- ◯ Using other medicines *(please specify)* ____________

Are you now taking or using medicines for:

- ◯ Diabetes (pills or shots)
- ◯ Nerves (tranquilizers)
- ◯ Sleeping
- ◯ Heart or blood pressure
- ◯ Blood (liver, iron pills)
- ◯ Stomach trouble (ulcer, other)
- ◯ Headaches
- ◯ Arthritis or rheumatism
- ◯ Allergy

Have you ever had a tumor or cancer? YES ◯ NO ◯ Where? ____________

Have you ever had a major operation? YES ◯ NO ◯ What kind? ____________

Have you ever been involved in a serious accident? YES ◯ NO ◯ Describe: ____________

YES	NO	
◯	◯	Following injuries, have you ever had bleeding problems?
◯	◯	Do injuries and cuts take longer to heal now than previously?
◯	◯	Have you had eye trouble recently?
◯	◯	Do you urinate more than 6 times a day?
◯	◯	Have you recently lost/gained weight unintentionally?
◯	◯	Is there a history of diabetes in your family?
◯	◯	Date of last medical exam ____ Month ____ Year
◯	◯	Have you come to this office for relief of pain?
		If YES, where is the pain? ____________
◯	◯	Have you had the pain more than 3 weeks?
◯	◯	Are you presently having dental pain?

Dental History

YES	NO	
◯	◯	Have you had your wisdom teeth removed?
◯	◯	Have you had orthodontic treatment?
		If YES, Dr. ____________ When ____________
◯	◯	Do you have unreplaced missing teeth?
		If YES, why haven't you had them replaced? ____________
◯	◯	Was it ever suggested?
◯	◯	Do you want implants?
◯	◯	Do you have difficulty swallowing?
◯	◯	Do your gums bleed when brushing your teeth?
◯	◯	Have you ever been told you have pyorrhea or gum disease?
◯	◯	Have you ever had professional instructions on dental home care?
◯	◯	Is any part of your mouth sensitive to temperature or pressure?
		If YES, which part? ____________
◯	◯	Does food catch between your teeth?
		If YES, where? ____________
◯	◯	Do you have any pain or soreness around the eyes or ears?
◯	◯	Do you have any unpleasant odor or taste in your mouth?
◯	◯	Are you dissatisfied with your teeth and their appearance?
◯	◯	Are you dissatisfied with the whiteness of your teeth?
◯	◯	Do you always have something to be treated or repaired when you visit a dentist?
◯	◯	Do you feel that in the past you have required a lot of dental work?
		If YES, has it been to replace previous dentistry or to repair a new decay? ☐ Replace ☐ New Decay
◯	◯	Are you aware that dental decay is essentially a childhood disease, and that most tooth filling procedures are to repair broken teeth or worn out restorations?
◯	◯	Do you feel that you will lose more teeth and eventually have to wear full dentures? If so, at what age? ____________
◯	◯	Are you deeply concerned about the finances required to return your mouth to dental health?

Occlusal Screening

YES	NO	
◯	◯	1. Do you clench or grind your teeth during the day?
◯	◯	2. Have you been made aware of clenching or grinding your teeth during the night?
◯	◯	3. Do you have chronic headaches or neck and shoulder pain?
◯	◯	4. Do you ever wake up with an awareness of or about your teeth or jaw like you've had them clenched in your sleep?
◯	◯	5. Do you have any awareness in the muscles of your neck or shoulders?
◯	◯	6. Do you have a tight or stiff neck?
◯	◯	7. Do you now, or have you ever had, pain in your jaw joint or the sides of your face (in and about the ears)?
◯	◯	8. Do you have a clicking jaw joint or have you ever experienced an inability to move your jaw or open your mouth widely?
◯	◯	9. Which side do you chew on? R ◯ L ◯ Both ◯
◯	◯	10. Do you know the meaning of traumatic occlusion?