

North Valley Family Dentistry

We would like to get to know you better!

Date _____

Patient Name _____ Male Female Single Married Other

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Employer _____ Work Phone _____

Social Security Number _____ Date of Birth _____ Referred by _____

For Insurance Purposes:

Name of Insurance Carrier _____ Group Number _____

Phone Number _____

Name of Cardholder _____ Cardholder's Date of Birth _____

Cardholder's Social Security Number _____ Cardholder's Employer _____

Dental History

In the last several months

have you experienced any of the following:

Sensitivity to:

Heat? Yes No

Cold? Yes No

Sweets? Yes No

Biting? Yes No

Food Impaction? Yes No

Bleeding, sore gums? Yes No

Unpleasant taste or odor? Yes No

Loose teeth/broken fillings? Yes No

Clicking of the jaw? Yes No

Pain (joints,ear,face)? Yes No

Difficulty opening or closing? Yes No

Difficulty chewing? Yes No

Grinding or clenching? Yes No

Bleeding, swollen/irritated gums? Yes No

Loose, tipped or shifting teeth? Yes No

Bad breath? Yes No

Have you ever had a reaction to a local anesthetic? Yes No

Are you dissatisfied with your teeth and their appearance? Yes No

Do you get frustrated b/c you always have something to be treated when you visit the dentist? Yes No

Have you ever had teeth removed? Yes No

How long have these teeth been missing? _____

Do you have any dental fears? Yes No

Are you concerned about the finances required to return your teeth to excellent dental health? Yes No

What is your present dental problem? _____

Do you have/had any of the following?

-Dentures Yes No

-Partial Dentures Yes No

-Braces Yes No

-Periodontal treatments Yes No

Please share the following dates:

-Your last cleaning _____/_____/_____

-Your last oral cancer screen _____/_____/_____

-Your last complete x-rays _____/_____/_____

Name of Previous Dentist _____

City _____ **State** _____

Phone Number _____

If you could whiten your teeth for a cost anyone could afford, would you do it? _____

Do you use chewing tobacco? Yes No

Do you smoke? Yes No

How much? _____ For how long? _____

If I could change my smile, I would:

-Make them brighter

-Make them straighter

-Close spaces

-Replace black metal fillings

with tooth-colored fillings

-Repair chipped teeth

-Replace missing teeth

-Replace missing crowns

that don't match

-Have a smile makeover

On a scale of 1-10, with 10 being the highest rating:

-How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

-Where would you rate your dental health now?

1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?

Health History

Do you have any general health problems? Yes No

If so, please specify _____

Are you currently under a physician's care? Yes No

Reason _____

Any medications? _____

Have you had surgery? Yes No

If so, please specify _____

To the best of your knowledge, are you, or have you ever been
Afflicted with

Sinus problems Yes No

Headaches Yes No

Stroke Yes No

Dizziness/fainting Yes No

Epilepsy Yes No

Asthma Yes No

Persistent cough Yes No

Allergies Yes No

Material allergies (latex, metal, chemicals) Yes No

Food Allergies Yes No

Drug Allergies _____

Osteoporosis Yes No

Diabetes Yes No

Tobacco habit Yes No

Blood disease Yes No

Heart Problems Yes No

Artificial heart valve Yes No

Heart murmur Yes No

Mitral valve prolapse Yes No

High blood pressure Yes No

Pacemaker Yes No

Kidney problems Yes No

Liver disease Yes No

Arthritis, Rheumatism Yes No

Artificial joints Yes No

Hepatitis Yes No

AIDS/HIV Yes No

Stomach problems Yes No

Cancer Yes No

Chemotherapy Yes No

Radiation treatment Yes No

Pregnancy/Due Date _____ Yes No