NEW PATIENT CHART

Part 1: Reason for your Visit and Dental History

What can we do for you? _____

When was your last visit at a dentist for a complete, meticulous and precise exam? _____

At your last examination, was there work left to be done that was not completed or things that were left on observation?

Would you like to share why you decided to change dentists?

On a scale of 0 to 10, what is your level of fear or anxiety at the dentist? (Circle one) 1 2 3 4 5 6 7 8 9 10

Is there something in particular that worries or bothers you at the dentist?

Do you have teeth that are sensitive to hot, cold, sweet, acid or pressure or when you eat?.....Yes ☐ No ☐

Does food get stuck between your teeth or does floss shred or get stuck anywhere? .....Yes ☐ No ☐

Have you ever had a toothache or pain? Or fillings that have fallen or broken?.....Yes ☐ No ☐

Please list: _____

Do your gums bleed, even if its just a little, when you brush or floss?.....Yes ☐ No ☐

At what frequency, on average, do you brush or floss? _____

To your knowledge, is there someone in our family that has gum disease? .....Yes ☐ No ☐

Are you always confident with your breath or do you sometimes have a bad taste in your mouth? ..... Yes ☐ No ☐

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MASTICATION AND FUNCTION

Do you watch out for hard food or biting harder food? .....Yes ☐ No ☐

Do you feel like you clench or grind your teeth, or feel like your teeth don't fit together evenly? .....Yes ☐ No ☐

Have you noticed a change in the appearance of your teeth, or are your teeth worn, cracked, thinner, translucent? ....Yes ☐ No ☐

Do you have frequent or repetitive headaches or pain around your head and neck? If so what area and what frequency?

Are you being treated by a chiropractor, an osteopath or massage therapist for your neck or head area? .....Yes ☐ No ☐

Please list

Does your jaw lock, make noise or pop when you chew or yawn? ..... Yes ☐ No ☐

Do you sleep lightly or do you move a lot during your sleep? .....Yes ☐ No ☐

APPEARANCE AND ESTHETICS

Are you satisfied with the appearance of your teeth esthetically or is there something you would like modified?

Have you ever whitened your teeth? When? What method did you use? Were you satisfied with the results?

Any other pertinent information?

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Part 2: Medical Questionnaire

PATIENT'S NAME _____ BIRTHDATE _____

ADDRESS _____ CITY _____ ZIP _____

STATE _____ HOME PHONE _____ CELL _____

EMAIL _____ OCCUPATION _____

EMERGENCY CONTACT _____ PRIMARY DOCTOR _____

DATE OF LAST MEDICAL EXAM _____ REASON FOR EXAM _____

How would you qualify your general health *(please circle one)* Excellent Good Fair Bad

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HAVE YOU EVER HAD ONE OF THE FOLLOWING:

Hospitalized for an injury or illness ..... Yes ☐ No ☐

Please list _____

Had an allergic reaction to *(please circle all that apply)*

Aspirin Ibuprofen Acetaminophen
Penicillin
Erythromycin
Tetracycline
Codeine
Local anesthetic
Fluoride
Metals (cobalt, nickel, steel, etc)
Latex

Heart issues ..... Yes ☐ No ☐
Tasting or smelling problems ..... Yes ☐ No ☐
Rheumatoid fever ..... Yes ☐ No ☐
Scarlet fever ..... Yes ☐ No ☐
High blood pressure ..... Yes ☐ No ☐
Low blood pressure ..... Yes ☐ No ☐
Heart valve or stint ..... Yes ☐ No ☐
ACV ..... Yes ☐ No ☐
Anemia or other blood problem ..... Yes ☐ No ☐
Extended bleeding ..... Yes ☐ No ☐
Emphysema ..... Yes ☐ No ☐
Tuberculosis ..... Yes ☐ No ☐
Asthma ..... Yes ☐ No ☐
Trouble sleeping or breathing, snoring, sinus .. Yes ☐ No ☐
Kidney disease ..... Yes ☐ No ☐
Liver disease ..... Yes ☐ No ☐
Jaundice ..... Yes ☐ No ☐

Thyroid or parathyroid disease ..... Yes ☐ No ☐
Hormonal deficiency ..... Yes ☐ No ☐
Cholesterol ..... Yes ☐ No ☐
Diabetes ..... Yes ☐ No ☐
Stomach ulcers ..... Yes ☐ No ☐
Digestion problems, gastric reflux ..... Yes ☐ No ☐
Arthritis ..... Yes ☐ No ☐
Glaucoma ..... Yes ☐ No ☐
Contact lenses ..... Yes ☐ No ☐
Injury to head and neck ..... Yes ☐ No ☐
Epilepsy or convulsions ..... Yes ☐ No ☐
Neurological problems ..... Yes ☐ No ☐
Viral infection and cold sores ..... Yes ☐ No ☐
Abscess or swelling in the mouth ..... Yes ☐ No ☐
Hay fever or hives ..... Yes ☐ No ☐
Venereal disease ..... Yes ☐ No ☐
Hepatitis ..... Yes ☐ No ☐

Which type? _____

AIDS-HIV ..... Yes ☐ No ☐
Tumors or abnormal lumps ..... Yes ☐ No ☐
Radiotherapy ..... Yes ☐ No ☐
Chemotherapy ..... Yes ☐ No ☐
Emotional problems ..... Yes ☐ No ☐
Psychiatric treatment ..... Yes ☐ No ☐
Anti-depression medication ..... Yes ☐ No ☐
Alcoholism or other addictions ..... Yes ☐ No ☐

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ARE YOU

Asthmatic ..... Yes ☐ No ☐
Currently being treated for other diseases ..... Yes ☐ No ☐
Aware of a change in your health ..... Yes ☐ No ☐
Treated for osteoporosis/osteopenia ..... Yes ☐ No ☐
Frequently tired or exhausted ..... Yes ☐ No ☐
Have frequent headaches or migraines..... Yes ☐ No ☐
A smoker/have you smoked in the past ..... Yes ☐ No ☐
Take birth control medication ..... Yes ☐ No ☐
Are you pregnant ..... Yes ☐ No ☐
Do you have prostate problems ..... Yes ☐ No ☐

Do you have other medical or surgical conditions that may affect your dental care?

Please make a list of all other medication or vitamins you've taken in the past 2 years.

Sign below please. Thank you for taking the time to fill out this form.

PATIENT _____ **DATE** _____

DENTIST _____ **DATE** _____

PJN DENTAL