WISPELWEY DENTAL
FAMILY, COSMETIC & IMPLANT DENTISTRY

PATIENT INFORMATION

Today's Date: ___/___/___

Name: ______________________ Nickname: ______________ ❐ Male ❐ Female

Birthdate: ___/___/___ Age: ______________________

❐ Child/Minor ❐ Single ❐ Married ❐ Divorced ❐ Widowed ❐ Seperated

Other family members seen by us: ______________________

Previous/Present Dentist: ______________________

IF MINOR:

School: ______________________ Grade: ______________________

CONTACT INFORMATION

Home Address: ______________________

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Home #: (_____) ______________ Cell #: (_____) ______________ Email: ______________________

INSURANCE INFORMATION

PRIMARY

Dental Coverage: ❐ Yes ❐ No

Insurance Company Name: ______________________

Insurance Company Address: ______________________

Insurance Company Phone #: ______________________ Group # (Plan, Local or Policy #): ______________

Insured's Name: ______________________ Relation: ______________ Insured's Birthdate: ____/____/____

Insured's ID#: ______________________ Insured's Employer: ______________________

SECONDARY

Dental Coverage: ❐ Yes ❐ No

WISPELWEY DENTAL
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Today's Date: ___/___/___ Name: ______________________ Nickname: ______________ Age: ________

Referred by: ______________ Previous Dentist: ______________ Physician Name & Specialty: ______________

Most Recent: dental exam: ___/___/___ x-rays: ___/___/___ treatment (not cleaning): ___/___/___ physical exam: ___/___/___

I would rate my general health: ❐ Excellent ❐ Good ❐ Fair ❐ Poor I would rate the condition of my mouth: ❐ Excellent ❐ Good ❐ Fair ❐ Poor

I see my dentist every: ❐ 3 mo. ❐ 4 mo. ❐ 6 mo. ❐ 12 mo. ❐ Not routinely My immediate concern: ______________

MEDICAL HISTORY

DO YOU OR HAVE YOU EVER HAD?

1. hospitalization for illness or injury ❐ Yes ❐ No
2. an allergic reaction to
   - aspirin, ibuprofen, acetaminophen, codeine penicillin ❐ Yes ❐ No
   - erythromycin ❐ Yes ❐ No
   - tetracycline ❐ Yes ❐ No
   - sulfa ❐ Yes ❐ No
   - local anesthetic ❐ Yes ❐ No
   - fluoride ❐ Yes ❐ No
   - metals (nickel, gold, silver...) ❐ Yes ❐ No
   - latex ❐ Yes ❐ No
   - milk ❐ Yes ❐ No
   - other ❐ Yes ❐ No
3. heart problems, or cardiac stent (within the last six months) ❐ Yes ❐ No
4. history of infective endocarditis ❐ Yes ❐ No
5. artificial heart valve, repaired heart defect (PFO) ❐ Yes ❐ No
6. pacemaker or implantable defibrillator ❐ Yes ❐ No
7. orthopedic implant (joint replacement) ❐ Yes ❐ No
8. rheumatic or scarlet fever ❐ Yes ❐ No
9. high or low blood pressure ❐ Yes ❐ No
10. a stroke (taking blood thinners) ❐ Yes ❐ No
11. anemia or other blood disorder ❐ Yes ❐ No
12. prolonged bleeding due to a slight cut (INR>3.5) ❐ Yes ❐ No
13. emphysema, shortness of breath, sarcoidosis ❐ Yes ❐ No
14. tuberculosis, measles, chicken pox ❐ Yes ❐ No
15. asthma ❐ Yes ❐ No
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus) ❐ Yes ❐ No
17. kidney disease ❐ Yes ❐ No
18. liver disease ❐ Yes ❐ No
19. jaundice ❐ Yes ❐ No
20. thyroid, parathyroid disease, or calcium deficiency ❐ Yes ❐ No
21. hormone deficiency ❐ Yes ❐ No
22. high cholesterol or taking statin drugs ❐ Yes ❐ No
23. diabetes (HbA1c =________) ❐ Yes ❐ No
24. stomach or duodenal ulcer ❐ Yes ❐ No
25. digestive disorders (i.e. celiac disease, gastric reflux) ❐ Yes ❐ No
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) ❐ Yes ❐ No
27. arthritis ❐ Yes ❐ No
28. autoimmune disease (i.e. rheumatoid arthritis, lupus, scleroderma) ❐ Yes ❐ No
29. glaucoma ❐ Yes ❐ No
30. contact lenses ❐ Yes ❐ No
31. head or neck injuries ❐ Yes ❐ No
32. epilepsy, convulsions (seizures) ❐ Yes ❐ No
33. neurological disorders (ADD/ADHD, prion disease) ❐ Yes ❐ No
34. viral infections and cold sores ❐ Yes ❐ No
35. any lumps or swelling in the mouth ❐ Yes ❐ No
36. hives, skin rash, hay fever ❐ Yes ❐ No
37. STI / STD / HPV ❐ Yes ❐ No
38. hepatitis (type___) ❐ Yes ❐ No
39. HIV / AIDS ❐ Yes ❐ No
40. tumor, abnormal growth ❐ Yes ❐ No
41. radiation therapy ❐ Yes ❐ No
42. chemotherapy, immunosuppressive medication ❐ Yes ❐ No
43. emotional difficulties ❐ Yes ❐ No
44. psychiatric treatment ❐ Yes ❐ No
45. antidepressant medication ❐ Yes ❐ No
46. alcohol / recreational drug use ❐ Yes ❐ No

ARE YOU:

47. presently being treated for any other illness ❐ Yes ❐ No
48. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) ❐ Yes ❐ No
49. taking medication for weight management ❐ Yes ❐ No
50. taking dietary supplements ❐ Yes ❐ No
51. often exhausted or fatigued ❐ Yes ❐ No
52. experiencing frequent headaches ❐ Yes ❐ No
53. a smoker, smoked previously or use smokeless tobacco ❐ Yes ❐ No
54. considered a touchy / sensitive person ❐ Yes ❐ No
55. often unhappy or depressed ❐ Yes ❐ No
56. taking birth control pills ❐ Yes ❐ No
57. currently pregnant ❐ Yes ❐ No
58. prostate disorders ❐ Yes ❐ No

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

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DENTAL HISTORY

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
2. Have you had an unfavorable dental experience? ❑ Yes ❑ No
3. Have you ever had complications from past dental treatment? ❑ Yes ❑ No
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? ❑ Yes ❑ No
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? ❑ Yes ❑ No
6. Have you had any teeth removed? ❑ Yes ❑ No

GUM & BONE

7. Do your gums bleed or are they painful when brushing or flossing? ❑ Yes ❑ No
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? ❑ Yes ❑ No
9. Have you ever noticed an unpleasant taste or odor in your mouth? ❑ Yes ❑ No
10. Is there anyone with a history of periodontal disease in your family? ❑ Yes ❑ No
11. Have you ever experienced gum recession? ❑ Yes ❑ No
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? ❑ Yes ❑ No
13. Have you experienced a burning sensation in your mouth? ❑ Yes ❑ No

TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years? ❑ Yes ❑ No
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? ❑ Yes ❑ No
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? ❑ Yes ❑ No
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? ❑ Yes ❑ No
18. Do you have grooves or notches on your teeth near the gum line? ❑ Yes ❑ No
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? ❑ Yes ❑ No
20. Do you frequently get food caught between any teeth? ❑ Yes ❑ No

BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) ❑ Yes ❑ No
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? ❑ Yes ❑ No
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? ❑ Yes ❑ No
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? ❑ Yes ❑ No
25. Are your teeth becoming more crooked, crowded, or overlapped? ❑ Yes ❑ No
26. Are your teeth developing spaces or becoming more loose? ❑ Yes ❑ No
27. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together? ❑ Yes ❑ No
28. Do you place your tongue between your teeth or rest your teeth against your tongue? ❑ Yes ❑ No
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? ❑ Yes ❑ No
30. Do you clench your teeth in the daytime or make them sore? ❑ Yes ❑ No
31. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth? ❑ Yes ❑ No
32. Do you wear or have you ever worn a bite appliance? ❑ Yes ❑ No

SMILE CHARACTERISTICS

33. Is there anything about the appearance of your teeth that you would like to change? ❑ Yes ❑ No
34. Have you ever whitened (bleached) your teeth? ❑ Yes ❑ No
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? ❑ Yes ❑ No
36. Have you been disappointed with the appearance of previous dental work? ❑ Yes ❑ No

LIST ALL MEDICATIONS, SUPPLEMENTS, AND OR VITAMINS TAKEN WITHIN THE LAST TWO YEARS.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature ______________________________ Date ___/___/___

Doctor's Signature ______________________________ Date ___/___/___