# Adair Dental Arts

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**Chart#:** _____
FOR OFFICE USE ONLY

**Patient Name:** _____ _____ ___ _____
Last First MI Preferred Name

**Title:** _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

**Birth Date:** _____ **SS#:** ___-__-____ **Prev. Visit:** _____

**Email Address:** _____ **Best time to call:** _____

**Phone:** _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

**Address:** _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

**How did you hear about our clinic? If from a friend or family member, please let us know their name in the space provided below so we may thank them!**

☐ Website ☐ Friend/Family (please let us know who) ☐ Advertisement - Newspaper/Magazine
☐ Yellow Pages ☐ Facebook ☐ Searching online for dental clinics
☐ Drove by our Clinic ☐ Other

**How would you like us to contact you as a reminder of your upcoming appointments? (Check all that apply)**

☐ Phone (home number) ☐ Phone (cell number) ☐ Phone (work number) ☐ Text ☐ Email

**Please provide us with two (2) emergency contacts. We will need name and phone number.**

**Please inform our office if you have any type of dental insurance coverage. Our staff is happy to file all claims for procedures to your insurance company. We ask that any co-pays, deductibles or full fees (dependant on insurance type), are paid at time of service.**

**Our patients are sent monthly statements of costs not covered by insurance companies. We ask you comply and promptly pay any balances incurred within our office.**

**Please initial in the space provided you have read these guidelines.**

_____

**Name of Insured:** _____ _____ ____
Last First MI

**Insured's Birth Date:** _____ **ID #:** _____ **Group #:** _____

**Insured's Address:** _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

**Insured's Employer Name:** _____

**Employer Address:** _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

**Patient's relationship to insured:** ◯ Self ◯ Spouse ◯ Child ◯ Other

**Insurance Plan Name:** _____

**Insurance Address:** _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

**DENTAL INSURANCE INFORMATION - SECONDARY POLICY**
**If Applicable**

**Name of Insured:** _____ _____ ____
Last First MI

**Insured's Birth Date:** _____ **ID #:** _____ **Group #:** _____

**Insured's Address:** _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

**Insured's Employer Name:** _____

**Employer Address:** _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

**Patient's relationship to insured:** ◯ Self ◯ Spouse ◯ Child ◯ Other

**Insurance Plan Name:** _____

**Insurance Address:** _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

**Please provide us with a brief medical and dental history. Knowing this information will allow us to provide you with an excellent dental experience.**

## DENTAL HISTORY

**What is your primary reason for making this dental appointment? Are you having any current concerns?**

_____

_____

**Name of your previous dentist and location (City, State)**

_____

_____

**When was your last dental cleaning? (Approximately)**

_____

_____

**Date of last Bitewing Xrays or Panoramic Film taken. (Approximately)**

_____

_____

**Date of most recent treatment (other than a cleaning). (Approximately)**

_____

_____

**I routinely see my dentist every:**

☐ 3 months ☐ 4 month ☐ 6 months ☐ 12 months ☐ Not routinely

**Please provide a "Yes" or "No" answer to the following questions.**

**PERSONAL HISTORY**

**Are you fearful of dental treatment?** ◯ Yes ◯ No

**Have you had an unfavorable dental experience?** ◯ Yes ◯ No

**Have you ever had complications from past dental treatment?** ◯ Yes ◯ No

**Have you ever had trouble getting numb or had any reactions to local anesthetic?** ◯ Yes ◯ No

**Did you ever have braces, orthodontic treatment, or had your bite adjusted?** ◯ Yes ◯ No

**Have you had any teeth removed?** ◯ Yes ◯ No

**FOR DOCTOR USE ONLY:**

_____

_____

_____

**SMILE CHARACTERISTICS**

**Is there anything about the appearance of your teeth that you would like to change?** ◯ Yes ◯ No

**Have you ever whitened (bleached) your teeth?** ◯ Yes ◯ No

**Have you felt uncomfortable or self conscious about the appearance of your teeth?** ◯ Yes ◯ No

**Have you been disappointed with the appearance of previous dental work?** ◯ Yes ◯ No

**FOR DOCTOR USE ONLY:**

**BITE AND JAW JOINT**

**Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)** ◯ Yes ◯ No

**Do you/would you have any problems chewing gum?** ◯ Yes ◯ No

**Do you/would you have any problems chewing bagels, baguettes, protein bars or other hard foods?** ◯ Yes ◯ No

**Have your teeth changed in the last 5 years, become shorter, thinner, worn?** ◯ Yes ◯ No

**Are your teeth crowding or developing spaces?** ◯ Yes ◯ No

**Do you have more than one bite and squeeze to make your teeth fit together?** ◯ Yes ◯ No

**Do you chew ice, bite your nails, use your teeth to hold objects or have any other oral habits?** ◯ Yes ◯ No

**Do you clench your teeth in the daytime or make them sore?** ◯ Yes ◯ No

**Do you have any problems with sleep or wake up with an awareness of your teeth?** ◯ Yes ◯ No

**Do you wear or have you worn a bite appliance?** ◯ Yes ◯ No

**FOR DOCTOR USE ONLY:**

**TOOTH STRUCTURE**

**Have you had any cavities within the past 3 years?** ◯ Yes ◯ No

**Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?** ◯ Yes ◯ No

**Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?** ◯ Yes ◯ No

**Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth?** ◯ Yes ◯ No

**Do you have grooves or notches on your teeth near the gum line?** ◯ Yes ◯ No

**Have you broken teeth, chipped teeth or had a toothache or cracked filling?** ◯ Yes ◯ No

**Do you get food caught between any teeth?** ◯ Yes ◯ No

**FOR DOCTOR USE ONLY:**

**GUM AND BONE**

**Do your gums bleed when brushing or flossing?** ◯ Yes ◯ No

**Have you ever been treated for gum disese or been told you have lost bone around your teeth?** ◯ Yes ◯ No

**Have you ever noticed an unpleasant taste or odor in your mouth?** ◯ Yes ◯ No

**Is there anyone with a history of periodontal disease in your family?** ◯ Yes ◯ No

**Have you ever experienced gum recession?** ◯ Yes ◯ No

**Have you ever had any teeth become loose (without an injury), or do you have difficulty eating an apple?** ◯ Yes ◯ No

**Have you experienced a burning sensation in your mouth?** ◯ Yes ◯ No

**FOR DOCTOR USE ONLY:**

## MEDICAL HISTORY

**Name of Physician and Specialty (General Practitioner, Internal Medicine, etc.)**

_____

_____

**Date of most recent examination (Approximately)** _____

**Purpose of examination** _____

**What is the estimate of your general health?**

☐ Excellent ☐ Good ☐ Fair ☐ Poor

**Recent hospitalization for illness or injury? Please explain.**

_____

_____

**Do you premedicate with antibiotics prior to dental treatment? Have you had a joint replacement or cardiac episode/treatment that would warrant you taking medication prior to any dental work?**

◯ Yes ◯ No

**Describe any current medical treatment, impending surgery or other treatments that may possibly affect your dental treatment.**

_____

_____

PLEASE INDICATE ANY CONDITIONS YOU HAVE HAD OR ARE CURRENTLY EXPERIENCING:

| | | | |
|---|---|---|---|
| ☐ *Pre-Med-see PtNotes | ☐ Allergy - Acetamin | ☐ Allergy - Anesthetic | ☐ Allergy - Aspirin |
| ☐ Allergy - Baycol | ☐ Allergy - Cefdinir | ☐ Allergy - Cephalexin | ☐ Allergy - Codeine |
| ☐ Allergy - Erythro | ☐ Allergy - Ibuprofen | ☐ Allergy - Latex | ☐ Allergy - Meperidine |
| ☐ Allergy - Morphine | ☐ Allergy - Oxycodone | ☐ Allergy - Penicillin | ☐ Allergy - Sulfa |
| ☐ Allergy - Tetracycl | ☐ Allergy - metals | ☐ Allergy -Minocycline | ☐ Allergy -Pravastatin |
| ☐ Allergy-Acetaminophe | ☐ Allergy-Azithromycin | ☐ Allergy-Erythromycin | ☐ Allergy-Hydrocodone |
| ☐ Allergy-Naproxen | ☐ Allergy-Vancomycin | ☐ Alzheimers | ☐ Anemia |
| ☐ Angioplasty/stents | ☐ Anxiety/Depression | ☐ Aortic Aneurysm | ☐ Aortic Stenosis |
| ☐ Arthritis | ☐ Artif heart valves | ☐ Artificial Joints | ☐ Asthma |
| ☐ Atrial Fibrillation | ☐ Autism | ☐ Benzocaine | ☐ Blood Disease |
| ☐ COPD | ☐ Cancer/Chemotherapy | ☐ Cardiac Stent | ☐ Cerebral Palsy |
| ☐ Cold sores/viral inf | ☐ Cystic Fibrosis | ☐ Dental Anxiety | ☐ Diabetes |
| ☐ Digestive/reflux | ☐ Diverticulitis | ☐ Early Onset Dementia | ☐ Emphysema |
| ☐ Epilepsy/Seizures | ☐ Excessive Bleeding | ☐ Fainting | ☐ Glaucoma |
| ☐ Glossalpharyneal | ☐ HIV/AIDS | ☐ Hashimoto's | ☐ Head Injuries |
| ☐ Heart Disease | ☐ Heart Murmur | ☐ Heart Surgery | ☐ Hepatitis |
| ☐ High Blood Pressure | ☐ High Cholesterol | ☐ Jaundice | ☐ Kidney Disease |
| ☐ Leukemia | ☐ Liver Disease | ☐ Low blood pressure | ☐ Lupus |
| ☐ Marfan Syndrome | ☐ Migraines | ☐ MitralValve Prolapse | ☐ Multiple Sclerosis |
| ☐ Neurologic Disorders | ☐ Osteoporosis | ☐ Other-see Pt Notes | ☐ Pacemaker |
| ☐ Radiation Treatment | ☐ Repair Heart defect | ☐ Respiratory Problems | ☐ Rheumatism |
| ☐ Seasonal Allergies | ☐ Sinus Problems | ☐ Stomach Ulcers | ☐ Stroke |
| ☐ Thyroid/Parathyroid | ☐ TraumaticBrainInjury | ☐ Tuberculosis | ☐ Tumors |
| ☐ Vertigo | | | |

- [ ] Wear contact lenses?
- [ ] Do you snore while sleeping?
- [ ] Aware of any change in your general health?
- [ ] Taking general dietary supplements (vitamins)?
- [ ] Subject to frequent headaches?
- [ ] Often unhappy or depressed?
- [ ] FEMALE - taking birth control pills?
- [ ] MALE - prostate disorders?
- [ ] Breathing or sleeping problems?
- [ ] Presently being treated for any other illness?
- [ ] Taking medication for weight management?
- [ ] Often exhausted or fatigued?
- [ ] Any lumps or swelling in the mouth?
- [ ] In treatment for depression, emotional or psychiatric issues?
- [ ] FEMALE - pregnant?

**If you have a condition not listed above, please make us aware. Knowing about other existing conditions will help us treat your dental needs.**

_____

_____

_____

**Are you a smoker or use chewing tobacco?** ◯ Yes ◯ No

**How long have you smoked or used tobacco products?** _____

**Did you previously smoke or use chewing tobacco?** ◯ Yes ◯ No

**If you indicated any cardiac (heart) related issues above, please explain here.**

_____

_____

**Please list all medications, supplements or vitamins you are currently taking or have taken within the last 2 years.**

_____

_____

_____

_____

_____

**Please list any medications you are currently taking, one medication per line:**

_____

_____

_____

_____

_____

**Response Date:** _____