$\hfill \square$  Heavy drinker: Consumed 2 to 3 drinks per day on average in past year

What is most important to you about the dental care you receive?  What is most important to you about the dental care you receive?  Big PICTURE  DEPTILIS  Check One: When there is something to be done, do you trend to be?  Check One: When there is something to be done, do you trend to be?  Check One: When there is something to be done, do you trend to be?  Check One: When there is something to be done, do you trend to be?  Check One: When there is something to be done, do you trend to be will a problem arises or handle in the past of the past you be read or hos done in the past you be read or hos done in the past year?  Dental Information  Yes No Unknown  Do you gums bleed when youbrush?  How often do you clean between your teeth?  Are you amouth breather?  Are you amouth breather?  Are you amouth breather?  Are you a mouth breather?  Are you a mouth breather?  Are you a mouth breather?  Do you they amouth breather?  Do you they amouth breather?  Do you to you they am not side of your paw?  Do you to you they am not side of your paw?  Do you to you they am not reflaque?  Do you to you have am not side of your paw?  Do you they am have breathing?  Do you they am when brushing?  Do you to you way and your teeth?  Do you they you when they have your your your your your your your your	Nam	ne (Fir	st and	Last):	Date:				
BIS PICTURE   OPERALS	Getting to know you								
WANT until a problem arises or   HANDLE   TBEFORE there is a crisis?	What	t is m	ost ir	mportant to you about the dental care you receive?	□ BIG PICTURE				
Yes No Unknown	-	u cou	ld ch	ange something about your smile, what would it	□ WAIT until a problem arises or				
Do your gums bleed when you brush?	Dental Information								
How often do you brush? /day / How often do you brush? /day / How often do you brush? / How often do you have dental check ups? // Have you had any problems associated with previous dental treatment or past dental experiences? // Have you are dental experiences? // Have you are dental experiences? // Have you had any sensation on longue? // Do you gent gent pain or fatigue? // Do you gent gent pain or fatigue? // Do you gent pain or fatigue? // Do you gent pain or fatigue? // Do you ware a nightguard, denture(s) or removable appliance? // Do you ware an indiguard, denture(s) or removable appliance? // Do you ware an indiguard, denture(s) or removable appliance? // Do you ware an indiguard, denture(s) or removable appliance? // Do you ware of longue. // Do you shore // How often do you ware of longue. // Do you have of longue. // Do you have benefit you have sheep appliance? // Do you have benefit you have sheep appliance? // Do you ware to health concern? // Do you ware up feeling refreshed? // Have you ever wom a CPAP? If yes, do/did you use it regularly? Explain: // Have you ever wom a CPAP? If yes, do/did you use it regularly? Exp	Yes	No	Unkı	nown	How often do you clean between your teeth?				
Have you ever had orthodonic treatment?   How often do you have dental check ups?   Have you been told you have gum disease?   Have you been told you have gum disease?   Have you been told you have gum disease?   Have you had any problems associated with previous dental treatment or past dental experiences?   Have you had any problems associated with previous dental treatment or past dental experiences?   Have you was a for loose teeth or broken fillings?   Are you a mouth breather?   Oral Habits (Check all that apply)				Do your gums blood when you brush?					
Do you have headaches, earaches or neck pain?   Have you been told you have gum disease?   Have you been told you have gum disease?   Have you been told you have gum disease?   Have you had any problems associated with previous dental treatment or past dental experiences?   Have you had any problems associated with previous dental treatment or past dental experiences?   Have you had any problems associated with previous dental treatment or past dental experiences?   Have you had any problems associated with previous dental treatment or past dental experiences?   Have you had any problems associated with previous dental treatment or past dental experiences?   Have you had any problems associated with previous dental treatment or past dental experiences?   To dental experiences?   Have you had any problems associated with previous dental treatment or past dental experiences?   To den									
Have you been told you have gum disease? Are you aware of loose teeth or broken fillings? Are you aware of loose teeth or broken fillings? Are you a mouth breather? Do you drequently get blisters on lips or mouth? Do you or gums swollen or tender? Do you or were get a burning sensation on tongue? Do you or were get a burning sensation on tongue? Do you or gums you on mouth or mouth? Do you experience clicking/popping in your jaw? Do you get jaw pain or fatigue? Do you get jaw pain or fatigue? Do you get jaw pain or fatigue? Do you were pour teeth? Do you were an injet guard, denture(s) or removable appliance?  Circle One: Are your teeth sensitive to COLD, HOT, SWEETS or PRESSURE?  Medical Information  Physician(s): Phone: () Name of Clinic: City:  Yes No Unknown Are you in good health? Have there been any changes in your health within the past year? Have you had any serious illness, operation or been hospitalized in the past 5 years? If so, what was the illness or health concern? Do you wake up feeling refreshed? Have you wake up feeling refreshed? Have you wake up feeling refreshed? None, I don't drink at all Light-drinker: Consumed less than 3 drinks per week on average Have you had any serious illness, or water get a dental experiences?  Have you alcohol consumption history? Recreational Drug Use Mariguana; type: Marigua									
				-	Have you had any problems associated with previous dental				
Are your gums swollen or tender? Are you a mouth breather? Do you frequently get blisters on lips or mouth? Do you can be a burning sensation on tongue? Do you experience clicking/popping in your jaw? Do you get jaw pain or fatigue? Which fluoride products do you use/consume? Toothpaste   Water   Rinses   None   Other   Do you sore or water   Rinses   None   Other   Do you under the care of a physician? If so, what are the conditions being treated? Have you had any serious illness, operation or been hospitalized in the past 5 years? If so, what was the illness or health concern? Do you consume snacks/beverages containing sugar between meals? Do you vance? Do you wake up feeling refreshed? Have you ever been told you have sleep apnea? Have you ever been told you have sleep apnea? Have you ever been told you have sleep apnea? None, I don't drink at all Light drinker: Consumed less than 3 drinks per week on average   Marijuana; type:					treatment or past dental experiences?				
Are you a mouth breather?									
Do you frequently get blisters on lips or mouth? Do you ever get a burning sensation on tongue? Do you chew on one side of your mouth? Do you experience clicking/popping in your jaw? Do you get jaw pain or fatigue? Do you get jaw pain or fatigue? Do you get jaw pain or fatigue? Do you have pain when brushing? Do you have pain when brushing? Do you wear a nightguard, denture(s) or removable appliance? Which fluoride products do you use/consume? Toothpaste   Water   Rinses   None   Other   Toothpaste   Water   Ri									
Or all Abits (Check all that apply)  Or apply (Day or all all all all all all all all all al				•					
Do you experience clicking/popping in your jaw?   Do you get jaw pain or fatigue?   Using teeth as a tool   Using teeth as a tool   Does food collect between your teeth?   Bite nails or other objects   Musical instruments with mouthpiece   Do you grind your teeth?   Bite nails or other objects   Musical instruments with mouthpiece   Do you grind your teeth?   Do you wear a nightguard, denture(s)   Toothpaste   Water   Rinses   None   Other   City:   City:   City:   City:   Toothpaste   Water   Rinses   None   Other   City:				Do you ever get a burning sensation on tongue?					
Do you get jaw pain or fatigue?   Using teeth as a tool   Bite nails or other objects   Bite nails or other objects   Musical instruments with mouthpiece   Do you wave pain when brushing?   Musical instruments with mouthpiece   Do you wave pain when brushing?   Musical instruments with mouthpiece   Do you wave pain when brushing?   Musical instruments with mouthpiece   Toothpaste   Which fluoride products do you use/consume?   Toothpaste   Water   Rinses   None   Other   Toothpaste				Do you chew on one side of your mouth?					
Dosy food collect between your teeth?   Bite nails or other objects   Do you have pain when brushing?   Musical instruments with mouthpiece   Do you grind your teeth?   Which fluoride products do you use/consume?   Or removable appliance?   Toothpaste   Water   Rinses   None   Other   Circle One: Are your teeth sensitive to COLD, HOT, SWEETS or PRESSURE?   Phone: (				Do you experience clicking/popping in your jaw?	□ Using teeth as a tool				
Do you have pain when brushing?   Musical instruments with mouthpiece				Do you get jaw pain or fatigue?					
Do you grind your teeth?				Does food collect between your teeth?					
Do you wear a nightguard, denture(s) or removable appliance?   Toothpaste   Water   Rinses   None   Other				Do you have pain when brushing?	Musical instruments with mouthpiece				
Circle One: Are your teeth sensitive to COLD, HOT, SWEETS or PRESSURE?  Medical Information  Physician(s):					Miliah fiyarida menduata da yay yaalaanayee				
Circle One: Are your teeth sensitive to COLD, HOT, SWEETS or PRESSURE?  Medical Information  Physician(s):									
Medical Information  Physician(s):	Circl	e One	e: Are						
Physician(s):				,					
Physician(s):									
Name of Clinic:	Med	ical Ir	nform	nation					
Name of Clinic:									
Yes No Unknown  Are you in good health? Have there been any changes in your health within the past year? Have there been any changes in your health within the past year? Have you under the care of a physician? If so, what are the conditions being treated? Have you had any serious illness, operation or been hospitalized in the past 5 years?  If so, what was the illness or health concern? Do you consume snacks/beverages containing sugar between meals? Do you snore? Do you wake up feeling refreshed? Have you ever been told you have sleep apnea? Have you ever worn a CPAP? If yes, do/did you use it regularly? Explain:  What is your alcohol consumption history? Recreational Drug Use None, I don't drink at all NONE Light drinker: Consumed less than 3 drinks per week on average									
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Have there been any changes in your health within the past year?  Have you under the care of a physician? If so, what are the conditions being treated? Have you had any serious illness, operation or been hospitalized in the past 5 years?  If so, what was the illness or health concern? Do you consume snacks/beverages containing sugar between meals? Do you snore? Do you wake up feeling refreshed? Have you ever been told you have sleep apnea? Have you ever worn a CPAP? If yes, do/did you use it regularly? Explain:  What is your alcohol consumption history? Recreational Drug Use None, I don't drink at all NONE Light drinker: Consumed less than 3 drinks per week on average				Are you in good health?					
Are you under the care of a physician? If so, what are the conditions being treated?  Have you had any serious illness, operation or been hospitalized in the past 5 years?  If so, what was the illness or health concern?  Do you consume snacks/beverages containing sugar between meals?  Do you snore?  Do you wake up feeling refreshed?  Have you ever been told you have sleep apnea?  Have you ever worn a CPAP? If yes, do/did you use it regularly? Explain:  What is your alcohol consumption history?  Recreational Drug Use  None, I don't drink at all  NONE  Light drinker: Consumed less than 3 drinks per week on average  Marijuana; type:									
Have you had any serious illness, operation or been hospitalized in the past 5 years?   If so, what was the illness or health concern?									
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<ul> <li>□ □ Have you ever worn a CPAP? If yes, do/did you use it regularly? Explain:</li> <li>What is your alcohol consumption history?</li> <li>□ None, I don't drink at all</li> <li>□ Light drinker: Consumed less than 3 drinks per week on average</li> <li>□ Marijuana; type:</li></ul>				· · · · · · · · · · · · · · · · · · ·					
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□ None, I don't drink at all □ Light drinker: Consumed less than 3 drinks per week on average □ Marijuana; type:	\A/L-	4 ic ··	011 <u>2</u> -	lackal concumption history?	Poorestianal Drug Has				
□ Light drinker: Consumed less than 3 drinks per week on average □ Marijuana; type:		_							
	_	-							

	-	our history of tobacco use?		Smokeless tobacco use		
		moked			□ Never used smokeless tobacco	
		smoker,pack(s) per			□ Current tobacco chewer	
	rmer	smoker, Age Began: Year Quit:			□ Former tobacco chewer, Year Quit:	
					□ Current vape user	
		. I to a constant of the const			□ Former vape user	
		aking any medications (Prescription or Over-the-Co	unter)?			
Nam	e of L	Orug Purpose				
Are y	ou al	lergic to or have you had a reaction to:				
□ L	ocal a	anesthetics 🏻 Penicillin or other antibiotics 🖨 Barbitui	rates, se	edativ	es or sleeping pills 🛛 Sulfa drugs	
	odeir	ne or other narcotics 🛛 Latex 🗀 lodine 🗀 Hay fever/se	easonal	□ Ме	etal	
Pleas	se list	any drugs or medicines that you cannot or prefer to not	t take:			
vvnai	t is yo	our preferred drug for mild and/or severe pain?				
					.,	
PLE	ASE (	X) A RESPONSE TO INDICATE IF YOU HAVE OR HA	AVE HA	D AN	Y OF THE FOLLOWING DISEASES OR PROBLEMS	
Yes	No		Yes	No		
					Immunoquipiroccion	
	П	Abnormal Bleeding			Immunosuppression	
_	_	Controlled? (circle one) Good Fair Poor AIDS or HIV			Mental health disorder Type:	
					Neurological disorders Type:	
		Anemia			Night sweats/Menopausal	
		Herpes Arthritis			Osteoporosis Persistent swollen glands	
					•	
		Rheumatoid Arthritis Asthma			Respiratory problems If yes, please specify:	
		Blood transfusion If yes, date:			Severe headaches/migraines	
		Cancer/chemotherapy/radiation			0 " 1 " 1 "	
		Cardiovascular diseases?			Sinus trouble	
		□ Angina Pectoris □ Heart Murmur			Sores or ulcers in the mouth	
		□ Bypass Surgery □ Mitral Valve Prolapse			Stroke If yes, date:	
		□ Pacemaker □ Rheumatic Fever			Systemic Lupus Erythematosus	
		□ Artificial Valves □ Stents			Tuberculosis	
		□ Heart Attack Date:			Thyroid problems	
		Chest pain/shortness of breath upon exertion			Ulcers	
		Chronic pain			Excessive urination/thirst	
		GE reflux, persistent heartburn, or GI disease			Have you ever been told you needed to pre-	
		Hemophilia			medicate for dental treatment?	
		Hepatitis, jaundice or liver disease			Are you pregnant?	
		High/Low blood pressure	Ш	ш	Are you pregnant:	
		Recurrent infection Type:	Do vo	ou hav	ve any condition not listed above that you think we	
		Diabetes should know about?				
		Epilepsy	SHOU	iu KNO	w about!	
		Fainting spells or seizures				
		Dry mouth				
		Joint replacement date:	Pless	se fee	I free to add any additional information you would like	
		Eating disorder Type:				
ш	ш		us to	know	about your medical or dental care:	

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any other member of his staff responsible for any action they take because of errors or omission that I may have made in the completion of this form.

Signature of Patient/ Legal Guardian						
	Date					
	BELOW: IN OFFICE USE ONLY					
I HAVE REVIEWED THE ATTACHED ME	DICAL/DENTAL HISTORY AND HAVE NOTED ANY CHANGES					
Date	Comments/Changes					
Signature of patient (or guardian)	Signature of Dentist/Hygienist					
Date	Comments/Changes					
Signature of patient (or guardian)	Signature of Dentist/Hygienist					
Date	Comments/Changes					
Signature of patient (or guardian)	Signature of Dentist/Hygienist					