# DENTAL HISTORY

Referred by_____ How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Previous Dentist _____ How long have you been a patient?_____Months/Years
Date of most recent dental exam _____/_____/_____ Date of most recent x-rays _____/_____/_____
Date of most recent treatment (other than a cleaning) _____/_____/_____
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

**WHAT IS YOUR IMMEDIATE CONCERN?** _____

**PLEASE ANSWER YES OR NO TO THE FOLLOWING:** YES NO

## PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____ ☐ ☐
2. Have you had an unfavorable dental experience? _____ ☐ ☐
3. Have you ever had complications from past dental treatment? _____ ☐ ☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ ☐ ☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ ☐ ☐
6. Have you had any teeth removed? _____ ☐ ☐

## SMILE CHARACTERISTICS

7. Is there anything about the appearance of your teeth that you would like to change? _____ ☐ ☐
8. Have you ever whitened (bleached) your teeth? _____ ☐ ☐
9. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ ☐ ☐
10. Have you been disappointed with the appearance of previous dental work? _____ ☐ ☐

## BITE AND JAW JOINT

11. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ ☐ ☐
12. Do you / would you have any problems chewing gum? _____ ☐ ☐
13. Do you / would you have any problems chewing bagels, baguettes , protein bars, or other hard foods? _____ ☐ ☐
14. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ ☐ ☐
15. Are your teeth crowding or developing spaces? _____ ☐ ☐
16. Do you have more than one bite and squeeze to make your teeth fit together? _____ ☐ ☐
17. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ ☐ ☐
18. Do you clench your teeth in the daytime or make them sore? _____ ☐ ☐
19. Do you have any problems with sleep or wake up with an awareness of your teeth? _____ ☐ ☐
20. Do you wear or have you ever worn a bite appliance? _____ ☐ ☐

## TOOTH STRUCTURE

21. Have you had any cavities within the past 3 years? _____ ☐ ☐
22. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ ☐ ☐
23. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ ☐ ☐
24. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____ ☐ ☐
25. Do you have grooves or notches on your teeth near the gum line? _____ ☐ ☐
26. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ ☐ ☐
27. Do you get food caught between any teeth? _____ ☐ ☐

## GUM AND BONE

28. Do your gums bleed when brushing or flossing? _____ ☐ ☐
29. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ ☐ ☐
30. Have you ever noticed an unpleasant taste or odor in your mouth? _____ ☐ ☐
31. Is there anyone with a history of periodontal disease in your family? _____ ☐ ☐
32. Have you ever experienced gum recession? _____ ☐ ☐
33. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ ☐ ☐
34. Have you experienced a burning sensation in your mouth? _____ ☐ ☐

Patient's Signature _____ Date_____

Doctor's Signature _____ Date _____

# MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination ioio _____ Purpose _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

| DO YOU HAVE or HAVE YOU EVER HAD: | YES | NO |
|---|---|---|
| 1. hospitalization for illness or injury_____ | ☐ | ☐ |
| 2. an allergic reaction to | | |
| ☐ aspirin, ibuprofen, acetaminophen, codeine | | |
| ☐ penicillin | | |
| ☐ erythromycin | | |
| ☐ tetracycline | | |
| ☐ sulfa | | |
| ☐ local anesthetic | | |
| ☐ fluoride | | |
| ☐ metals (nickel, gold, silver, _____) | | |
| ☐ latex | | |
| ☐ other _____ | | |
| 3. heart problems, or cardiac stent within the last six months __ | ☐ | ☐ |
| 4. history of infective endocarditis _____ | ☐ | ☐ |
| 5. artificial heart valve, repaired heart defect (PFO) _____ | ☐ | ☐ |
| 6. pacemaker or implantable defibrillator _____ | ☐ | ☐ |
| 7. artificial prosthesis (heart valve or joints) _____ | ☐ | ☐ |
| 8. rheumatic or scarlet fever_____ | ☐ | ☐ |
| 9. high or low blood pressure_____ | ☐ | ☐ |
| 10. a stroke (taking blood thinners) _____ | ☐ | ☐ |
| 11. anemia or other blood disorder _____ | ☐ | ☐ |
| 12. prolonged bleeding due to a slight cut (INR > 3.5) _____ | ☐ | ☐ |
| 13. emphysema, shortness of breath, sarcoidosis _____ | ☐ | ☐ |
| 14. tuberculosis, measles, chicken pox_____ | ☐ | ☐ |
| 15. asthma_____ | ☐ | ☐ |
| 16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus) | ☐ | ☐ |
| 17. kidney disease _____ | ☐ | ☐ |
| 18. liver disease _____ | ☐ | ☐ |
| 19. jaundice _____ | ☐ | ☐ |
| 20. thyroid, parathyroid disease, or calcium deficiency _____ | ☐ | ☐ |
| 21. hormone deficiency _____ | ☐ | ☐ |
| 22. high cholesterol or taking statin drugs _____ | ☐ | ☐ |
| 23. diabetes (HbA1c =_____) _____ | ☐ | ☐ |
| 24. stomach or duodenal ulcer _____ | ☐ | ☐ |
| 25. digestive disorders (i.e. celiac disease, gastric reflux) _____ | ☐ | ☐ |

| | YES | NO |
|---|---|---|
| 26. osteoporosis/osteopenia (i.e. taking bisphosphonates) __ | ☐ | ☐ |
| 27. arthritis, rheumatoid arthritis, lupus _____ | ☐ | ☐ |
| 28. glaucoma_____ | ☐ | ☐ |
| 29. contact lenses _____ | ☐ | ☐ |
| 30. head or neck injuries _____ | ☐ | ☐ |
| 31. epilepsy, convulsions (seizures) _____ | ☐ | ☐ |
| 32. neurologic disorders (ADD/ADHD, prion disease) _____ | ☐ | ☐ |
| 33. viral infections and cold sores _____ | ☐ | ☐ |
| 34. any lumps or swelling in the mouth_____ | ☐ | ☐ |
| 35. hives, skin rash, hay fever_____ | ☐ | ☐ |
| 36. STI / STD _____ | ☐ | ☐ |
| 37. hepatitis (type ___) _____ | ☐ | ☐ |
| 38. HIV / AIDS _____ | ☐ | ☐ |
| 39. tumor, abnormal growth_____ | ☐ | ☐ |
| 40. radiation therapy_____ | ☐ | ☐ |
| 41. chemotherapy, immunosuppressive_____ | ☐ | ☐ |
| 42. emotional problems _____ | ☐ | ☐ |
| 43. psychiatric treatment_____ | ☐ | ☐ |
| 44. antidepressant medication _____ | ☐ | ☐ |
| 45. alcohol / street drug use _____ | ☐ | ☐ |
| **ARE YOU:** | | |
| 46. presently being treated for any other illness _____ | ☐ | ☐ |
| 47. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) _____ | ☐ | ☐ |
| 48. taking medication for weight management (i.e. fen-phen) | ☐ | ☐ |
| 49. taking dietary supplements_____ | ☐ | ☐ |
| 50. often exhausted or fatigued _____ | ☐ | ☐ |
| 51. experiencing frequent headaches_____ | ☐ | ☐ |
| 52. a smoker, smoked previously or use smokeless tobacco _ | ☐ | ☐ |
| 53. considered a touchy person _____ | ☐ | ☐ |
| 54. often unhappy or depressed_____ | ☐ | ☐ |
| 55. FEMALE - taking birth control pills _____ | ☐ | ☐ |
| 56. FEMALE - pregnant _____ | ☐ | ☐ |
| 57. MALE - prostate disorders _____ | ☐ | ☐ |

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)

_____

List all medications, supplements, and or vitamins taken within the last two years

| Drug | Purpose | Drug | Purpose |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Ask for an additional sheet if you are taking more than 6 medications

**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 _____

**So that we may provide you with the best care,**
**Please fill out these forms completely.**

## PATIENT INFORMATION

**Today's Date** _____

Name _____
Address _____City _____State _____Zip _____
Date of Birth _____Age_____Social Security #_____
Home #_____Work # _____Ext # _____Cell #_____
E-Mail _____
Occupation_____Employer_____(If Student) School_____
If married please list spouse's Name:_____ Tel #_____
What are your hobbies? _____ Favorite Restaurant _____

**If the patient is a minor please fill out the following**:

Parent or Guardian Name _____
Address_____City_____State_____Zip_____
Home #_____Work #_____Ext # _____Cell #_____

## ACCOUNT INFORMATION

Person financially responsible for this account _____
Relationship to patient _____Home #_____Work #_____Cell #_____
Billing Address (If different from patient)_____
City _____State_____Zip_____
Employer _____Business Phone #_____

Drivers License #_____
Credit Card #_____Exp_____Cvv Code: _____

## INSURANCE INFORMATION

**If you have and would like for our office to assist you in filling, please provide the following information.**

_____
Insurance Company Employee Employer Date of Birth

_____

Employee Social Security # ID # Group #

## EMERGENCY CONTACT

Are other members of your family patient' at this office? YES NO
Please list their names _____
Person to contact in case of an emergency _____
Please list phone numbers where they may be reached_____
Address_____City_____State _____Zip_____
**So that we may thank them, who referred you to our office?** _____

## FINANCIAL COMMITMENT

I understand responsibility for payment for Dental Services provided in this office for my dependents and myself is mine, due and payable at the time of services are rendered. Patient
Signature_____Date_____
Parent/Responsible Party Signature_____Date_____

## PATIENT CONSENT

I understand that information that I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.
Patient Signature_____Date_____
Parent/Responsible Party Signature_____Date_____

## AUTHORIZATION FOR SUBMISSION OF CLAIMS & ASSIGNMENT OF BENEFITS

I authorize the office of **Joni K. Wallace**, to submit claims for payment for services to the insurance company named below, on my behalf and in my name, and assign such provider the group insurance benefits otherwise payable to me. I understand that I am financially responsible for any balances not satisfied by my insurance benefits, regardless of the basis for nonpayment by my insurance carrier. In the event that payment is not made in full within forty-five (45) days of filing the claim with the insurance company, I authorize the office of **Dr. Joni K. Wallace**, to charge my credit card for the balance due from the insurance carrier.

_____
Insurance Company Patient Name (if minor Parent/Guardian)

_____
Credit Card Type & Name on Credit Card Credit Card Number Expiration Cvv Code

_____
Signature Date

## AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize the office of **Dr. Joni K. Wallace** to provide any insurance company, health care service plan, self-insures, or their repetitive, any and all information and records (including x-rays) about my medical history, or about service rendered or treatment given to me, that is needed to review, investigate or evaluate any claim for benefits. If my coverage is under a group master agreement held by my employer, an association, trust fund, union or entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit.

_____Patient
Name (If Minor Parent/ Guardian)

_____
Signature Date

THANK YOU FOR FILLING OUT THIS FORM COMPLETELY. IT WILL ENABLE US TO RENDER COMPRENSIVE CARE. IF YOU HAVE ANY QUESTIONS AT ANY TIME PLEASE FEEL TO ASK US. WE ARE HERE TO HELP YOU REACH AND MAINTAIN YOUR MAXIMUM HEALTH POTENTIAL.

# Cancellation Policy

As a patient in our clinic, it will be your responsibility to keep scheduled appointments. The clinic will require notification of cancellation at least 3 business days prior to the appointment or earlier if possible (this excludes Friday, and weekends). This can be done at any time by calling our clinic at 512-236-1611. The clinic will consider a "failed appointment" at any time a patient has not given the advanced notice required about or has failed to arrive within 10 minutes of their appointment time. A late cancellation fee may be charged.

When a patient fails two appointments in a 3-year period, the clinic will no longer schedule appointments for that patient. Please sign and date below as your acknowledgement that you have read and understand our cancellation policy.

_____ _____

Patient's signature Date

_____

Patient's printed name