Welcome to Tooth Booth

Please complete the following information (front and back)

Patient Name_____ Nickname_____ Age_____

Address: _____ Cell/home#: _____ Email: _____

Emergency contact: _____ Phone#: _____ Relation: _____

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/treatment_____

Name of Physician_____ Phone#: _____

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)to10(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, and at what age?_____	☐	☐
6. Have you had any teeth removed, missing teeth that never developed, or lost teeth dueto injury or facial trauma?_____	☐	☐
GUM AND BONE	YES	NO
7. Do your gums bleed sometimes or are they ever uncomfortable when brushing or flossing?_____	☐	☐
8. Have you ever had or been told you have gum loss, gum disease, or bone loss between your teeth?_____	☐	☐
9. Have you ever noticed an unpleasant taste, odor in your mouth, or swollen and puffy gums?_____	☐	☐
10. Is there anyone with a history of periodontal disease in your family?_____	☐	☐
11. Have you ever experienced gum recession, or can you see more of the roots of your teeth?_____	☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or feel them move when chewing?_____	☐	☐
13. Have you experienced a burning, painful sensation, or metallic taste in your mouth?_____	☐	☐
TOOTH STRUCTURE	YES	NO
14. Have you had any cavities within the past 3 years?_____	☐	☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing or chewing any food?	☐	☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?_____	☐	☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?_____	☐	☐
18. Do you have grooves or not chew on your teeth near the gum line?_____	☐	☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?_____	☐	☐
20. Do you frequently get food caught between any teeth?_____	☐	☐
BITE AND JAW JOINT	YES	NO
21. Does your jaw joint ever have pain, sounds (popping, cracking), or experience limited opening or locking?_____	☐	☐
22. Do you feel like you need to pull your lower jaw back, when you try to bite your back teeth together?_____	☐	☐
23. Do you avoid or have difficulty chewing gum, raw carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?_____	☐	☐
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?_____	☐	☐
25. Are your teeth becoming more crooked, crowded, or overlapped?_____	☐	☐
26. Are your teeth developing spaces or becoming more loose?_____	☐	☐
27. Do you have to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together better?_____	☐	☐
28. Do you place your tongue between your teeth or close your teeth against your tongue?_____	☐	☐
29. Do you chewie, bite your nails, use your teeth to hold objects, or have any other oral habits?_____	☐	☐
30. Do you clench or grind your teeth together in the daytime/nighttime or ever make them sore?_____	☐	☐
31. Do you have any problems with sleep (i.e., restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?_____	☐	☐
32. Do you wear or have you ever worn a bite appliance?_____	☐	☐
SMILE CHARACTERISTICS	YES	NO
33. Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (color, spaces ,size ,shape)	☐	☐

34. Have you ever bleached(whitened) your teeth? ☐ ☐
35. Have you felt uncomfortable or self-conscious about the appearance of your teeth? ☐ ☐
36. Have you been disappointed with the appearance previous dental work? ☐ ☐

MEDICAL HISTORY

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 or bad reaction to any of the following: ☐ ☐
   - ○ aspirin, ibuprofen, acetaminophen, codeine
   - ○ penicillin
   - ○ erythromycin
   - ○ tetracycline
   - ○ sulfa
   - ○ local anesthetic
   - ○ fluoride
   - ○ chlorhexidine (CHX)
   - ○ Iodine
   - ○ metals (nickel, gold, silver,)
   - ○ latex
   - ○ nuts
   - ○ fruit
   - ○ milk
   - ○ red dye
   - ○ other
3. heart problems, or cardiac stent with in the last six months ☐ ☐
4. history of infective endocarditis ☐ ☐
5. artificial heart valve, repaired heart defect (PFO) ☐ ☐
6. pacemaker or implantable defibrillator ☐ ☐
7. orthopedic or soft tissue implant (e.g., joint replacement) ☐ ☐
8. heart murmur, 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 (or INR>3.5) ☐ ☐
13. pneumonia, emphysema, shortness of breath, sarcoidosis ☐ ☐
14. chronic ear infections, tuberculosis, measles, chickenpox ☐ ☐
15. breathing problems (e.g., asthma, stuffy nose, sinus congestion) ☐ ☐
16. sleep problems (e.g., sleep apnea, snoring, insomnia,) ☐ ☐
17. kidney disease ☐ ☐
18. liver disease or jaundice ☐ ☐
19. vertigo (e.g.," the room is spinning") ☐ ☐
20. thyroid, parathyroid disease, or calcium deficiency ☐ ☐
21. hormone deficiency or imbalance ☐ ☐
22. high cholesterol or takings tatin drugs ☐ ☐
23. diabetes (HbA1c=) ☐ ☐
24. stomach or duodenal ulcer ☐ ☐
25. digestive or eating disorders (e.g., gastric reflux, bulimia, anorexia, celiac disease, Crohn's disease, or any inflammatory bowel disease) ☐ ☐
26. osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g., bisphosphonates) ☐ ☐
27. arthritis or gout ☐ ☐
28. Auto immune disease (e.g., rheumatoid arthritis, lupus, scleroderma) ☐ ☐
29. glaucoma ☐ ☐
30. contact lenses ☐ ☐
31. head or neck injuries ☐ ☐
32. epilepsy, convulsions(seizures) ☐ ☐
33. neurologic disorders (e.g., Alzheimer's disease, dementia) ☐ ☐
34. Viral infections (e.g. Cold sores) bacteria linfections0 ☐ ☐
35. Any lumps or swelling in the mouth ☐ ☐
36. hives, skin rash, hay fever ☐ ☐
37. STI/STD/HPV ☐ ☐
38. hepatitis(type) ☐ ☐
39. HIV/AIDS ☐ ☐
40. tumor, abnormal growth ☐ ☐
41. radiation therapy ☐ ☐
42. chemotherapy, immunosuppressive medication ☐ ☐
43. difficulties with stress management ☐ ☐
44. psychiatric treatment, antidepressants ☐ ☐
45. concentration problems or ADD/ADHD ☐ ☐
46. alcohol/recreational drug use ☐ ☐

AREYOU:

47. presently being treated for any other illness ☐ ☐
48. aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea) ☐ ☐
49. taking medication for weight management ☐ ☐
50. taking dietary supplements, vitamins, and/or probiotics ☐ ☐
51. often exhausted or fatigued ☐ ☐
52. experiencing frequent headaches or chronic pain ☐ ☐
53. a smoker, smoked previously or other (e.g., smokeless tobacco, vaping, e-cigarettes, and cannabis) ☐ ☐
54. considered a touchy/sensitive person ☐ ☐
55. often unhappy or depressed ☐ ☐
56. taking birth control pills ☐ ☐
57. currently pregnant ☐ ☐
58. diagnosed with a prostate disorder ☐ ☐

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, vitamins, and/or probiotics taken within the last two years.

Drug	Purpose

*Please note your appointment is the time we reserve for you and we do need **2 business days** notice for **no charge rescheduling**, otherwise **$120 per hour FOR SHORT NOTICE or NO SHOW FEE** will be charged to your account.*

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

Patient's Signature: _____ Doctor's Signature: _____ Date: _____

(Person responsible for account)