Boulder Holistic Dentistry

Name ____________________ Birthdate __________ HomeÁÚ@}^Á____________________

Cell Phone ______________ Preferred Contact number __________ May we leave a message on voice mail? ___

Home Address ______________________________ Email____________________

City____________________ Zip______________ÁÁ

Workplace ______________________________ Occupation ____________________Á

In case of emergency, notify: ______________________________ Emergency Phone ______________Á

Whom may we thank for referring you? ____

DENTAL HISTORY

What is the purpose of your visit? ____

Are any teeth sensitive to hot, cold, sweets or pressure? __________ yes no

Can you chew food satisfactorily? ______________________ yes no

Do you clench, grind or grit your teeth? ____________________ yes no

Have you been told you snore? ________________________ yes no

Have you every been diagnosed with Obstructive Sleep Apnea? ____ yes no

Do you get pain in your jaw near your ears? ________________ yes no

Do you get headache, earache, neck or back pain? ____________ yes no

Are you happy with the appearance of your teeth? ____________ yes no

Do you use dental floss or other hygiene aids regularly? __________ yes no

Have you had dental X-rays taken in the last two years? __________ yes no

Please check if you have had:

_____ root canal treatment
_____ periodontal treatment (gums)
_____ orthodontic treatment (braces)
_____ extractions
_____ broken jaw
_____ head injury
_____ canker or other soresÁ
_____ trench mouth (ANUG)Á
_____ oral tumor or growth

MEDICAL HISTORY

Who is your physician? ______________________________ Phone______________________

Are you in good health? ______________________________ yes no

Are you under a physician's care for any problem? ______________ yes no

When was your last physical exam? ______________________

Have you ever had a serious illness or operation? ______________ yes no

Do you take any medication now, or have you in the last year? ____ yes no

If yes, what? ________________________________

Have you had any adverse reaction to penicillin, codeine, "novocaine" or any other drugs? ____________________ yes no

Women: Are you, or might you be, pregnant? ________________ yes no

Are you nursing? ______________________________ yes no

Have you gone through menopause? ________________ yes no

Please check if you have had:

_____ asthma
_____ allergies
_____ allergy to metals or jewelry
_____ diabetes
_____ high blood pressure
_____ heart disease
_____ chest pain
_____ hepatitis
_____ blood transfusion
_____ epilepsy or seizures
_____ thyroid condition
_____ kidney disease
_____ respiratory disease
_____ joint replacement
_____ AIDS/HIV
_____ digestive problems
_____ excessive bleeding
_____ easy bruising
_____ benign tumor
_____ malignant tumor, cancer
_____ radiation treatment

SIGNATURE ________________________________ **DATE** ____________________

NAME

RECORD #

DATE

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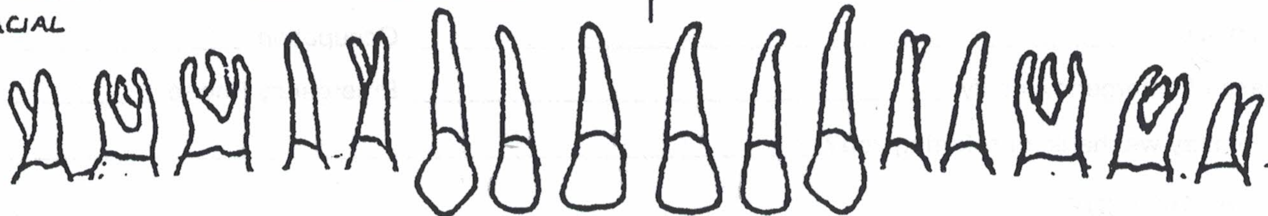

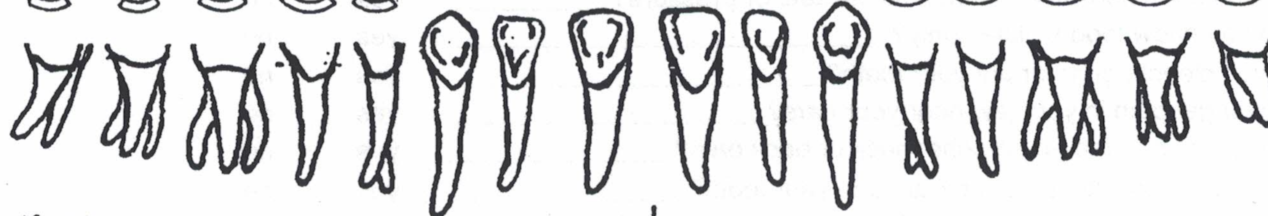

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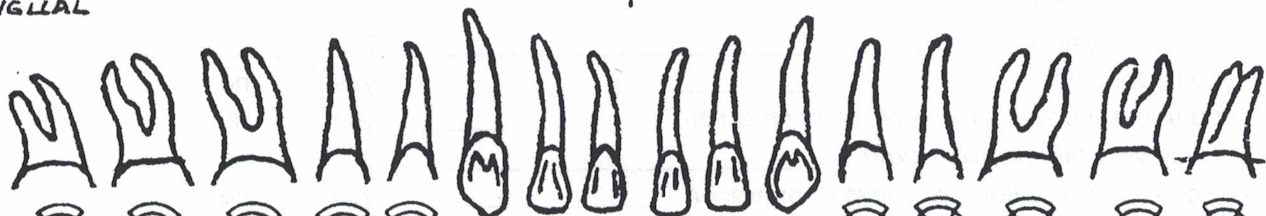

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REMARKS