Today's Date: _____/_____/______

Patient Information

Mr. /Mrs. /Ms. /Dr.: ____
First Middle Last Name

Home Address:____
Street City/Town State Zip

Phone #s: (H) ___________________(W) _____________________(C)______________________

Date of Birth: _______/_______/_______ Sex: M / F SS#: ________-______-__________

E-mail:____

Employer Name: _____________________________Occupation:___________________________

Work/School Address:____
Street City/town State Zip

Person to contact in case of emergency: ______________________________________

Relationship:_____________ Phone #1:_______________ Phone #2: ______________________

Personal Physician:_________________________________ Phone: ________________________

Address:____
Street City/Town State Zip

Person responsible for account (if other than self): ______________________________

Address:____
Street City/Town State Zip

Home Phone:__________________________ Business Phone:______________________________

Who may we thank for referring you to our practice?_________________________________

Dental History

1. What reason brings you to our office?____

   ____
2. Items you use for daily oral hygiene: (check all that apply)

   ☐ Toothbrush (hard, medium, soft) ☐ Electric tooth brush ☐ Dental floss

   ☐ Stimulator (rubber tip) ☐ Water device ☐ Toothpicks
3. What is your reaction to having dental treatment: (check one):

   ☐ I dread it. ☐ I worry about it. ☐ I don't mind it.
4. When was the last time you had a full series (**about 20 films**) of dental X-rays taken?

   Date: ______/______/______
5. Are you under the care of a periodontist? YES / NO

   Dr. _______________________ Phone: _______________________
6. When choosing restorative dentistry, do you wish to have: (check one)

   ☐ Highest Quality ☐ Most Economical

Olga Baczara DMD
CENTER FOR FINE DENTISTRY

Do you have or have you ever had: (please circle YES, NO, or DK = Don't Know):

7.	Your physician recommend antibiotics before dental treatment	Yes	No	DK
8.	Difficulty or pain when opening your mouth wide	Yes	No	DK
9.	Difficulty or pain when chewing your food	Yes	No	DK
10.	Ear pain, pain in front of the ears, ringing in the ears	Yes	No	DK
11.	Pain in the face, jaws eyes throat or neck .	Yes	No	DK
12.	Frequent headaches	Yes	No	DK
13.	Jaw noises that bother you or others	Yes	No	DK
14.	Teeth sensitive to chewing, temperature, sweets etc.	Yes	No	DK
15.	A feeling that your teeth are shifting or loosening	Yes	No	DK
16.	A bad taste in your mouth	Yes	No	DK
17.	Bleeding gums	Yes	No	DK
18.	A gum abscess or infection	Yes	No	DK
19.	Root canal treatment (endodontics)	Yes	No	DK
20.	Gum surgery or treatment (periodontics)	Yes	No	DK
21.	Braces (orthodontics) If YES, how long did the treatment take_________. When was treatment completed?_________	Yes	No	DK
22.	Have you noticed or has anyone told you, you clench your jaws or grind your teeth at night?	Yes	No	DK

Medical History

1.	Is a doctor currently treating you? If YES, for what reason(s):	Yes	No	DK
2.	Are you taking medications? If YES, please list them:	Yes	No	DK
3.	Are you allergic or sensitive to any medicine or substance (e.g. penicillin, aspirin, barbiturate, codeine, iodine, sulfa, latex, acrylic, etc.) If YES, please list them:	Yes	No	DK
4.	Do you smoke or chew tobacco? If YES, how many a day:	Yes	No	DK
5.	Have you had any heart trouble (e.g. hear surgery/murmur, pacemaker, mitral valve prolapse, angina, etc.) If YES, please list them:	Yes	No	DK

Do you have or have you ever had:

6.	Kidney disease	Yes	No	DK
7.	Hepatitis/liver disease	Yes	No	DK
8.	High/low blood pressure	Yes	No	DK
9.	Shortness of breath	Yes	No	DK
10.	Swelling of the ankles	Yes	No	DK
11.	Anemia	Yes	No	DK
12.	Rheumatic Fever	Yes	No	DK
13.	Frequent nose bleeds	Yes	No	DK
14.	Aids/HIV	Yes	No	DK
15.	Epilepsy (fainting spells, seizures)	Yes	No	DK
16.	Stomach trouble or ulcers	Yes	No	DK
17.	Tuberculosis	Yes	No	DK
18.	Cortizone treatment	Yes	No	DK
19.	Psychiatric treatment	Yes	No	DK
20.	Joint replacement or implanted prosthetic devices	Yes	No	DK

21.	Asthma	Yes	No	DK
22.	Diabetes (you or a relative)	Yes	No	DK
23.	Anorexia or Bulimia	Yes	No	DK
24.	Thyroid Disease	Yes	No	DK
25.	Venereal Disease	Yes	No	DK
26.	Skin Disease (hives, skin rash)	Yes	No	DK
27.	Any painful or swollen joints	Yes	No	DK
28.	Cancer or tumor	Yes	No	DK
29.	Radiation or Chemotherapy	Yes	No	DK
30.	Unexplained bruises	Yes	No	DK
31.	Prolonged unexplained bleeding	Yes	No	DK
32.	Bad reaction to local anesthesia	Yes	No	DK
33.	Chemical dependency	Yes	No	DK
34.	For women: Are you pregnant or nursing. If YES what month of pregnancy are you:	Yes	No	DK

35. Do you have any other condition of which special note should be taken? YES / NO. If YES, please note:

___

The above information is accurate and complete to the best of my knowledge.

Date:______________________ Patient Signature:______________________________