Date

Month Day Year

Driver's License

Patient's Name

First Name Middle Name Last Name

Person Filling Out This Form (if the patient is a minor)

First Name Middle Name Last Name

Relationship to the Patient

Email

example@example.com

Phone Number

Address

Street Address

Street Address Line 2

State

City

Zip Code

Person Responsible for Payment

First Name Middle Name Last Name

Date of Birth

Month Day Year

SSN/INS ID:

Gender

Please Select

Marital Status

Please Select

Employer

Occupation

Home Number

Work Phone

Patient's Spouse Name

First Name Middle Name Last Name

Spouse's Employer

Occupation

Work Phone

DENTAL INSURANCE INFORMATION

Insured's Name

Insured's Date of Birth

Month Day Year

Insured's Address (If different from above)

Street Address

Street Address Line 2

City State

Zip Code

Insured's Social Security

Insured's Employer

Insurance Company Name

Group # and Member ID#

Insurance Address and Phone

EMERGENCY INFORMATION

Local Friend or Relative not living with you

Complete Address

Phone Number

GETTING TO KNOW YOU

Source of Referral

Please Select

Whom may we thank for referring you?

Is another member of your family or relative a patient in our practice?

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a through diagnosis of my dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary, I fully understand that using anesthetics, sedatives and other medication as necessary, I fully understand that using anesthetic agents embodies certain risks, I understand that I can ask for a complete recital of any possible complications.

4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written, printed or electronic records that are individually identifiable as mine for the purpose of carrying out treatment, payment, education, promotion and health care operations.

PRIVACY POLICY

○ I have chosen NOT to receive a copy of the privacy policy. I understand a copy is available. Please refer to the link below.

PRIVACY POLICY

○ I have chosen NOT to receive a copy of the privacy policy. I understand a copy is available at any time on the website: www.walnutcreek.net/forms

Date

Month Day Year

Patient's, Parent's or Guardian's Signature:

DENTAL HISTORY

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

Month Day Year

Date of most x-rays

Month Day Year

Date of most recent treatment other than cleaning

Month Day Year

I routinely see my dentist every:

Please Select

WHAT IS YOUR IMMEDIATE CONCERN?

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY

	Yes	No
1. Are you fearful of dental treatment?	○	○

Scale of 1 to 10

	1	2	3	4	5	6	7	8	9	10	
Least	○	○	○	○	○	○	○	○	○	○	Most

	Yes	No
2. Have you ever had an unfavorable dental experience?	○	○
3. Have you ever had complications from past dental treatment?	○	○
4. Have you ever had trouble getting numb or reactions to local anesthetic	○	○
5. Did you ever have braces, orthodontic treatment or had your bite adjusted?	○	○
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma?	○	○

GUM AND BONE

	Yes	No
7. Do your gums bleed or are they painful when brushing or flossing?	○	○
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth	○	○
9. Have you ever noticed an unpleasant taste or odor in your mouth?	○	○
10. Is there anyone with a history of periodontal disease in your family?	○	○
11. Have you ever experienced gum recession?	○	○
12. Are your teeth becoming loose on their own (without an injury), or do you have difficulty eating an apple?	○	○
13. Have you ever experienced a burning sensation 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 ever feel too little or do you have difficulty swallowing 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 avoid brushing any part of your mouth?	○	○
18. Do you have grooves or notches 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. Do you have problems with your jaw join? (pain, sounds, limited opening, locking or popping)	○	○
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together?	○	○
23. Do you/ would you have any problems with chewing bagels, baguettes, protein bars or other hard food?	○	○
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 you teeth developing spaces or becoming more loose?	○	○
27. Do you have trouble finding you bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?	○	○
28. Do you place your tongue between your teeth or close your teeth against your tongue?	○	○
29. Do you chew ice, 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 or make them sore?	○	○
31. Do you have any problems with sleep or wake up with 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 teeth that you would like to change?	○	○
34. Have you ever whitened (bleached) your teeth?	○	○

35. Have you ever felt uncomfortable or self-conscious about the appearance of your teeth? ○ ○

36. Have you been disappointed with the appearance of previous dental work? ○ ○

Patient's, Parent's or Guardian's Signature:

Date

Month Day Year

DOCTOR'S SIGNATURE: _____ DATE: _____

Patient's Name

Patient's Name

First Name Last Name

Age

Name of Physician/and their specialty

Most recent physical examination

Month Day Year

Purpose

What is your estimate of your general health?

Please Select

HAVE YOU EVER HAD THE FOLLOWING:

	Yes	No
1. hospitalization for illness or injury	○	○

2. allergic reaction to:

- ☐ aspirin, ibuprofen, acetaminophen
- ☐ penicillin
- ☐ erythromycin
- ☐ codeine
- ☐ local anesthetic
- ☐ fluoride
- ☐ metals (gold, stainless steel)
- ☐ latex
- ☐ any other medications _____

	Yes	No
3. heart problems or cardiac stent (within last 6 months)	○	○

	Yes	No
4. history of infective endocarditis	○	○
5. artificial heart valve, repaired heart defect (PFO)	○	○
6. pacemaker or implantable defibrillator	○	○
7. orthopedic implant (joint replacement)	○	○
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, sarcoidosis	○	○
14. tuberculosis, measles, chicken pox	○	○
15. asthma	○	○
16. breathing or sleep problems (i.e. 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	○	○
24. stomach or duodenal ulcer	○	○
25. digestive disorders (i.e. gastric reflux)	○	○
26. osteoporosis/osteopenia (taking bisphosphonates)	○	○
27. arthritis	○	○
28. glucoma	○	○
29. contact lenses	○	○
30. head or neck injuries	○	○

31. epilepsy, convulsions (seizures)	○	○
32. neurological problems (attention deficit disorder)	○	○
33. viral infections and cold sores	○	○
34. any lumps or swelling in the mouth	○	○
35. hives, skin rash, hay fever	○	○
36. STD / HPV / STI	○	○
37. hepatitis	○	○
38. HIV / AIDS	○	○
39. tumor, abnormal growth	○	○
40. radiation therapy	○	○
41. chemotherapy	○	○
42. emotional problems	○	○
43. psychiatric treatment	○	○
44. antidepressant medication	○	○
45. alcohol / drug dependency	○	○
46. presently being treated for other illness	○	○
47. aware of any change in your general health	○	○
48. taking medication for weight management	○	○
49. taking dietary supplements	○	○
50. often exhausted or fatigue	○	○
51. experiencing frequent headaches	○	○
52. a smoker or smoked previously	○	○
53. considered a touchy / sensitive person	○	○
54. often unhappy or depressed	○	○
55. easily upset or irritated	○	○
56. FEMALE: taking birth control pills	○	○
57. FEMALE: pregnant	○	○
58: MALE: prostate disorders	○	○

Describe any current medical treatment, impending surgery, or other treatment that may possibly

affect your dental treatment

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

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

Patient's Signature

DOCTOR'S SIGNATURE: _____ DATE: _____

Link to NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

Date

Month Day Year