Tim Burgiss & AJ Carangelo
"Excellence in Dentistry with a Christian Heart"

Date _____

Last Name | Dr, Mr., Mrs., Ms. | First Name | Middle

Name you go by | Name of Spouse or Guardian

Date of Birth | Social Security # | Employer

Home Address | City | State Zip | Home Phone - Cell Phone

In case of Emergency | Phone #

Preferred Pharmacy:_____ Dental Insurance :Yes/No_____

Who May we Thank for referring you?_____

What is your present dental concern?_____

DENTAL HISTORY

1. HAVE YOU LOST ANY OF YOUR NATURAL TEETH? ❑ YES ❑ NO HOW? _____
2. HAVE THEY BEEN REPLACED? ❑ YES ❑ NO HOW?_____
3. DATE AND TYPE OF LAST DENTAL X-RAYS? _____
4. HOW WOULD YOU RATE YOUR PRESENT DENTAL HEALTH? ❑ EXCELLENT ❑ GOOD ❑ POOR
5. HOW WOULD YOU LIKE TO RATE YOUR FUTURE DENTAL HEALTH? ❑ EXCELLENT ❑ GOOD ❑ POOR
6. ARE YOU HAPPY WITH THE APPEARANCE OF YOUR TEETH? ❑ YES ❑ NO ❑ IF NOT, WHY? _____

_____

_____

7. HAVE YOU NOTICED:	YES	NO
A. GROWTHS, SWELLING, SORE SPOTS	❑	❑
B. PAIN OR TENDERNESS IN YOUR TEETH	❑	❑
C. BLEEDING GUMS	❑	❑
D. SENSITIVE TEETH	❑	❑
E. FOOD CATCHING BETWEEN TEETH	❑	❑
F. BAD BREATH	❑	❑

8. GENERAL DENTAL INFORMATION:	YES	NO
A. HAVE YOU BEEN SHOWN HOW TO FLOSS YOUR TEETH?	❑	❑
B. HAVE YOU BEEN TREATED FOR GUM DISEASE?	❑	❑
C. HAVE YOU HAD BRACES TO STRAIGHTEN YOUR TEETH?	❑	❑
D. DO YOU HAVE DIFFICULTY IN SWALLOWING?	❑	❑

9. PROBLEMS WHICH MAY BE RELATED TO YOUR OCCLUSION (BITE) OR JAW JOINT. HAVE YOU HAD, OR BEEN AWARE OF:					
A. TIRED FEELING IN FACE WHILE CHEWING	❑	❑	D. CLENCHING OR GRINDING YOUR TEETH	❑	❑
B. RINGING OR PAIN IN EAR	❑	❑	E. HEADACHES	❑	❑
C. PAIN AROUND EARS, EYES, NECK, HEAD	❑	❑	F. POPPING NOISES IN THE JAW JOINT	❑	❑

10. WHICH ITEMS DO YOU USE REGULARLY? ❑ HAND TOOTHBRUSH ❑ DENTAL FLOSS ❑ ELECTRIC TOOTHBRUSH ❑ WATER SPRAY
❑ TOOTHPICKS, STIMULATORS , ETC. ❑ RUBBER TIP ❑ Other _____
11. HAVE YOU HAD ANY UNFAVORABLE DENTAL EXPERIENCES? ❑ YES ❑ NO _____
12. DO YOU DESIRE TO MAINTAIN YOUR OWN TEETH AND AVOID DENTURES AS LONG AS POSSIBLE? ❑ YES ❑ NO

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
						Yellow Jaundice	◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X_____ Date:_____

Reviewed By: (Signature) Date