TWOHIG DENTISTRY

Twohig Dentistry Dental and Oral Health Information

Patient's name:_____ **Date:**_____

Please describe any specific dental problem or discomfort you are having at this time:

_____

_____

How long has it been present? _____

If you have had any of the following dental care, please list the dentists and approximate dates:

- **Periodontal (gum) treatment or surgery:**_____
- **"Braces" or any type of orthodontic treatment:**_____
- **Dental implants:**_____
- **Any other type of oral surgery:**_____

Your Dental Health:

- **How do you rate your overall dental health? _____Good _____Fair _____Poor**
- **How many times a <u>day</u> do you brush your teeth? _____**
- **How many times a <u>week</u> do you floss your teeth? _____**

Do you have/ have you had/ have you noticed any of the following signs or symptoms in your head, neck, or mouth? (Please check Yes or No for each question):

	Yes	No
Teeth that are sensitive to hot, cold, sweets, or biting pressure?		
A clicking, snapping or difficulty when chewing?		
An unpleasant taste or persistent bad breath?		
Difficulty opening or moving the jaws?		
Does food catch between your teeth?		
Difficulty speaking or changes in your voice?		
Do your gums bleed when brushing?		
Difficulty moving your tongue or "tongue tied"?		
Red, swollen, tender, bleeding, or sore gums?		
Loose or separating teeth?		
Gums that have pulled away from the teeth?		
Changes in the way your teeth fit together?		
Pus between the teeth and gums?		
A color change of the tissue in your mouth?		
Avoid any area when brushing or chewing?		
Pain, tenderness, numbness or earaches?		
Do you clench or grind your teeth?		
Any lumps, swelling, or swollen glands?		
Sores, ulcers, or rough spots?		
Do you snore?		

If you are a new patient to the practice:

- **Date of last dental visit?** _____
- **Dentist name?** _____
- **City and state?** _____

TWOHIG DENTISTRY

Do you use any of the following? (Please check Yes or No for each question)

	Yes	No
Mechanical (electric) toothbrush?		
If yes, which type or brand?		
Flossing aids (floss holder, threaders, etc.)?		
Waterpik?		
Fluoride treatments or supplementals at home?		
If yes, which ones?		
Mouthwash or oral rinses?		
If yes, what brand?		

Please check Yes or No for each question:

	Yes	No
Do you have any missing teeth that have not been replaced?		
If so, why have you decided to not replace them?		
Do you wear any removable dental appliances (dentures, partials, ortho, etc.)?		
If yes, what type and for how long?		
Have you ever had your teeth whitened or bleached?		
Would you like to have your teeth whitened or bleached?		
How do you feel about the appearance of your teeth?		
What would you change if you could?		
Are the finances required to return your mouth to excellent health a concern?		
Do you feel you always need something treated or repaired when you visit a dentist?		
Do you feel you will eventually wear dentures?		
Have you ever had any complications from an extraction or dental treatment?		
If yes, please explain.		
Have you ever had any major trauma or injury to your head, neck, or mouth?		
If yes, please explain.		

TWOHIG DENTISTRY

Health Information and History

Patient's name:_____ **Date:**_____

Date of Birth:_____

If you are completing this form for another person:

- **Your Name:**_____
- **Phone:**_____
- **Relationship:**_____

Emergency Contact Information (if not same as listed above):

- **Name:**_____**Phone:**_____
- **Relationship:**_____

Primary Physician:

- **Name:**_____**Phone:**_____
- **City and State**_____

Other Physician & Specialists:

- **Name:**_____**Phone:**_____
- **City and State**_____

Other Physician & Specialists:

- **Name:**_____**Phone:**_____
- **City and State**_____

Please check Yes or No to the following questions.

	Yes	No
Within the last 3 years, have you been hospitalized or had surgery?		
If yes, please give reasons and dates:		
Have you ever been instructed to take any medications or take any special		
precautions before any dental appointments?		
If yes, please explain.		
Are you taking any drugs, medications, or treatments at this time?		
(If you brought a complete list, please give to the receptionist instead)		
Prescribed:		
Prescribed:		
Prescribed:		
Over the counter medications (Aspirin, allergy medication, sleep aids, etc.)?		
Are you having or have you ever had radiation or chemotherapy treatments?		
Are you taking or have you ever been treated with Bisphosphonates (i.e. Fosamax)?		
Are you allergic to or have you ever had any unsual reaction to:		
Latex?		
Fluoride?		
Metals or Jewelry?		
Nitrous Oxide (laughing gas)?		
Dental Anesthesia?		
General Anesthesia?		

TWOHIG DENTISTRY

Health Information and History (continued)

Patient's Name:_____

Do you have, or have you ever had any of the following? (Check YES or NO for each question)

	Yes	No		Yes	No
Rheumatic heart disease?			Arthritis?		
Rheumatic fever?			Glaucoma or any eye disease?		
Heart murmur?			Epilepsy or other seizure disorder?		
Heart valve(s) damage?			Any kidney problems?		
Mitral valve prolapse?			Ulcers, acid reflux, or stomach		
Artificial heart valve?			problems?		
Pacemaker?			A compromised immune system		
Stroke or CVA?			(Lupus, HIV, AIDS, radiation,		
High blood pressure?			immune problems, etc.)?		
Low blood pressure?			An active sexually transmitted		
Hepatitis, jaundice, or other			disease (STD)?		
liver problems?			Any mental health issues?		
Hemophilia or bleeding disorder?			Treatment for any pyschiatric		
Excessive bleeding from any cut			condition?		
or incident?			Anemia?		
Diabetes or blood sugar problems?			Any artificial joint, joint surgery,		
Any form or cancer?			or prosthesis?		
Any organ transplant?			If yes, what joint area?		
Sleep apnea?			When was the operation?		
For women only:					
Are you pregnant?			Do you think you might be		
If yes, what is your due date?			pregnant?		
Are you taking hormone			Are you using birth control		
replacement therapy?			medication?		

Are you allergic to any medications _____Yes _____No
If yes, please list medications:
_____

Do you have any other conditions, diseases, or medical problems, or is there ANY other information that you would like us to know about, or that we should be made aware of? _____Yes _____No
If yes, please explain:_____
_____
_____
_____
_____

TWOHIG DENTISTRY

Oral Health Risk Factors

Patient's Name:_____

Please answer the questions below. (Check YES or NO for each question, where applicable)

	Yes	No
1. Do you smoke, or have you ever smoked?		
If no, proceed to question 2.		
The amount that you are presently smoking (check all that apply)		
None (quit smoking completely)		
An occasional cigar — An occasional cigarette		
Less than 1 pack of cigarettes per day — A few cigarettes per day		
1-2 packs of cigarettes per day — 2 or more packs per day		
Cigars on a daily/regular basis — Occasional pipe smoker		
A pipe on a daily/regular basis		
If you have quit smoking, when did you quit?		
How many years have you or did you smoke?		
2. Did you/have you EVER chew/chewed tobacco or use/used snuff or other		
similar substances (if no, proceed to queston 3)		
Are you still using smokeless tobacco or snuff?		
When did you quit?		
How many years did you use or have you used smokeless tobacco?		
3. Approximate average amount of alcholic beverages presently consumed per week?		
None		
Less than 1 per week — 1-5 drinks — 6-11 drinks		
11-20 drinks — over 20 drinks		
4. Do you have or have you ever had a substance abuse problem?		
If yes, please describe:		
5. Do you presently use any recreational drugs?		
List:		
6. Do you have or have you ever had an eating disorder?		
If yes, please describe:		
7. Do you have or have you ever had any head, neck, or mouth piercings?		
List:		
8. Do you have or have you ever been informed that you have been infected with		
an oncogenic strain (possibly cancer causing) of the Human Papilloma Virus (HPV)?		
9. Please list your history or any family member's history of cancer:		

CONSENT- To the best of my knowledge, all of the preceding information is correct and if there is ever any change in health, or medications, this practice will be informed of the changes without fail. I also consent to allow this practice to contact any healthcare provider(s) and to have the patient's health information released to aid in care and treatment. I also hereby consent to allow diagnosis, proper health care and treatment to be performed by this practice for the above named individual until further written notice.

I understand there are no guarantees or warranties in health or dental care.

Signature_____ Date: _____

(Parent or guardian, if patient is a minor)

TWOHIG DENTISTRY

Patient Information

Patient Name: _____ Date:_____

Gender: _____ Male _____ Female Family Status: _____ Single _____Married _____Child _____Other

Birth date: _____ Phone: home_____ cell _____ work _____

Address:

_____ZIP_____

Email Address: _____

Social Security #_____

Whom may we thank for referring you to our practice? _____

Do you have a preference in treating doctor? _____

Spouse or Responsible Party Information

Relationship to Patient: _____

Name: _____

Birth date : _____ Email address:_____

Phone: _____ Address: _____

Employment Information

Employer Name:_____ Phone: _____

Address: _____

Primary Insurance Information

Primary Dental Insurance:

Name of Insured:_____

Insured's Birth date:_____ ID#/ SS #:_____ Group#_____

Insured's Address:_____

Insured's Employer Name:_____

Employer Address: _____

Relationship to insured: _____

Insurance Plan Name: _____

Insurance Address: _____

TWOHIG
DENTISTRY

Secondary Insurance Information:

Name of Insured:_____

Insured's Birth date:_____ ID#:_____ Group#_____

Insured's Address:_____

Insured's Employer Name:_____

Employer Address for Secondary Insurance:

Patient's Relationship to insured: _____

Insurance Plan Name: _____

Insurance Address: _____

Consent for Services:

The undersigned hereby authorizes the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctors to make a thorough diagnosis of the patient's dental needs. I also authorize the doctors to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk.

I give my permission for the doctors or the staff to leave messages on my answering machine regarding my dental care.

I give my permission for the doctors or the staff to leave a message regarding my dental care with a spouse of family member at the number supplied by me.

I understand that my dental insurance is a contract between the insurance carrier and me and not between the insurance carrier and the doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the doctor. Any payments received by the doctor from my insurance coverage will be credited to my account or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance. I understand that where appropriate, credit reports, may be obtained.

Signature of patient, parent, or guardian (responsible party):

Signature: _____
Date: _____
Relationship to patient: _____