Riverview Dental

Welcome to our practice!

The information requested on these three questionnaires (personal, dental and medical history) is essential to providing you with the highest standard of dental care. The protection and privacy of your personal information is important to our office and we are committed to collecting, using and disclosing this information responsibly.

This Patient is ○ Adult ○ Child

Name:_____ **Date of Birth (mm/dd/yyyy)**

Address:_____ **Email:**_____

Home Phone:_____ **Cell:** _____ **Work:**_____

Employer:_____ **May we call you at work?** ○ **Yes** ○ **No**

IN CASE OF EMERGENCY:

Name:_____

Relation to patient:_____ **Phone:**_____

Whom may we thank for referring you?_____

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DENTAL HISTORY

1. Who was your former dentist?

   _____

2. When was your last dental examination?

   _____

3. How do you feel about your past dental treatment?

   _____

4. What is your reason for seeking dental treatment?

   _____

5. Do any of your teeth ache?

   _____

6. Do you have any clicking/popping or pain in your jaw?

   _____

7. Do you experience headaches?_____ If so, how often?_____
8. Have you ever had any teeth extracted?_____
9. How often do you brush?_____ How often do you floss?_____
10. Do your gums bleed when you brush or feel tender or swollen?_____
11. Have you ever had any surgery to your face or jaw?_____
12. Are you nervous about going to the dentist?_____
13. Please describe in your own words your present dental health.

    _____

    _____

    _____

SMILE ASSESSMENT

1. Are you happy with your smile? Yes____ No____Somewhat_____
2. Is there anything you would like to change about your smile? (i.e.: color, shape…)
3. If given the choice would you prefer white composite fillings over silver amalgam fillings? Yes____ No_____

Permit for Operations:

This is to certify that I, undersigned, consent to the preforming of the dental and oral surgery procedures agreed to be necessary or advisable including the use of local anesthetic and that I will assume responsibilities for fees associated with those procedures.

Patient (Parent) Signature: _____ Date:_____

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***ALERT:*_____**

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ _____ **Date:**_____

1. Are you being treated for any medical condition at present or within the past 2 years? Yes or No
   If yes, please explain:_____
   _____
2. Have you ever been hospitalized and/or was surgery performed?_____
3. Have you recently, or are you presently taking any prescription or non-prescription drugs incl. herbal remedies? Yes or No Please list:_____
4. Have you ever had an allergic reaction to any medication, e.g. penicillin?_____
   _____
5. Do you have any allergies? _____Please list:_____
   _____
6. Do you become breathless or have chest pains when walking or climbing stairs?_____
7. Do you bleed EXCESSIVELY from a cut, or do you bruise easily?_____
8. Have you gained or lost excessive weight recently?_____
9. Do you smoke or use tobacco products?_____
10. **INDICATE WHICH OF THE FOLLOWING YOU PRESENTLY HAVE OR EVER HAD**: (please circle)

A.I.D.S.
Artificial heart valve
Cancer
Diabetes (Type 1&2)
Head & Neck injuries
Heart murmur
Herpes & Cold sores
Liver disease
Organ transplant & implant
Chemotherapy
Thyroid disease
Visual impairment
Anemia
Artificial joint
Celiac disease
Epilepsy & seizures
Heart disease
Rheumatic fever
High & low blood pressure
Lung disease
Sinus trouble
Stomach problems & ulcers
Tuberculosis
Hearing impairment
Angina pectoris
Blood disorders
Crohn's disease
Fainting & dizziness
Heart attack
Hepatitis A, B or C
Kidney disease
Mental & nervous disorder
Radiation therapy
Stroke
Venereal disease
other:_____

11. Do you have, or have ever had, any condition, disease or problem not listed above?
    _____
12. Is there anything else we should be aware of regarding your health?
    _____
13. **WOMEN ONLY**: Are you taking birth control pills?_____
    Are you pregnant or suspect you may be?_____Due date_____

Signature:_____ **Date**:_____