

ANGELA COTEY, DDS



VILLAGE  
**SMILE CARE**

*Comprehensive and  
Family Dentistry*

## Patient Information

Name: LAST \_\_\_\_\_ FIRST \_\_\_\_\_ MI \_\_\_\_\_

Preferred name: \_\_\_\_\_

Marital status: MARRIED \_\_\_ SINGLE \_\_\_ CHILD \_\_\_ OTHER \_\_\_

Birth date: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address: STREET \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

Phone: HOME \_\_\_\_\_ CELL \_\_\_\_\_ WORK \_\_\_\_\_

Email: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: HOME \_\_\_\_\_ CELL \_\_\_\_\_ WORK \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

# MEDICAL HISTORY

Patient Name \_\_\_\_\_ Nickname \_\_\_\_\_ Age \_\_\_\_\_  
 Name of Physician/and their specialty \_\_\_\_\_  
 Most recent physical examination \_\_\_\_\_ Purpose \_\_\_\_\_  
 What is your estimate of your general health?  Excellent  Good  Fair  Poor

<b>DO YOU HAVE or HAVE YOU EVER HAD:</b>	<b>YES</b>	<b>NO</b>		<b>YES</b>	<b>NO</b>
1. hospitalization for illness or injury _____	<input type="checkbox"/>	<input type="checkbox"/>	26. osteoporosis/osteopenia (i.e. taking bisphosphonates) _____	<input type="checkbox"/>	<input type="checkbox"/>
2. an allergic or bad reaction to any of the following: <input type="checkbox"/> aspirin, ibuprofen, acetaminophen, codeine <input type="checkbox"/> penicillin <input type="checkbox"/> erythromycin <input type="checkbox"/> tetracycline <input type="checkbox"/> sulfa <input type="checkbox"/> local anesthetic <input type="checkbox"/> fluoride <input type="checkbox"/> metals (nickel, gold, silver, _____) <input type="checkbox"/> latex <input type="checkbox"/> nuts _____ <input type="checkbox"/> fruit _____ <input type="checkbox"/> other _____	<input type="checkbox"/>	<input type="checkbox"/>	27. arthritis _____	<input type="checkbox"/>	<input type="checkbox"/>
3. heart problems, or cardiac stent within the last six months _____	<input type="checkbox"/>	<input type="checkbox"/>	28. autoimmune disease _____ (i.e. rheumatoid arthritis, lupus, scleroderma)	<input type="checkbox"/>	<input type="checkbox"/>
4. history of infective endocarditis _____	<input type="checkbox"/>	<input type="checkbox"/>	29. glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>
5. artificial heart valve, repaired heart defect (PFO) _____	<input type="checkbox"/>	<input type="checkbox"/>	30. contact lenses _____	<input type="checkbox"/>	<input type="checkbox"/>
6. pacemaker or implantable defibrillator _____	<input type="checkbox"/>	<input type="checkbox"/>	31. head or neck injuries _____	<input type="checkbox"/>	<input type="checkbox"/>
7. orthopedic implant (joint replacement) _____	<input type="checkbox"/>	<input type="checkbox"/>	32. epilepsy, convulsions (seizures) _____	<input type="checkbox"/>	<input type="checkbox"/>
8. rheumatic or scarlet fever _____	<input type="checkbox"/>	<input type="checkbox"/>	33. neurologic disorders (ADD/ADHD, prion disease) _____	<input type="checkbox"/>	<input type="checkbox"/>
9. high or low blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	34. viral infections and cold sores _____	<input type="checkbox"/>	<input type="checkbox"/>
10. a stroke (taking blood thinners) _____	<input type="checkbox"/>	<input type="checkbox"/>	35. any lumps or swelling in the mouth _____	<input type="checkbox"/>	<input type="checkbox"/>
11. anemia or other blood disorder _____	<input type="checkbox"/>	<input type="checkbox"/>	36. hives, skin rash, hay fever _____	<input type="checkbox"/>	<input type="checkbox"/>
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	<input type="checkbox"/>	<input type="checkbox"/>	37. STI/STD/HPV _____	<input type="checkbox"/>	<input type="checkbox"/>
13. pneumonia, emphysema, shortness of breath, sarcoidosis _____	<input type="checkbox"/>	<input type="checkbox"/>	38. hepatitis (type _____) _____	<input type="checkbox"/>	<input type="checkbox"/>
14. tuberculosis, measles, chicken pox _____	<input type="checkbox"/>	<input type="checkbox"/>	39. HIV/AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>
15. asthma _____	<input type="checkbox"/>	<input type="checkbox"/>	40. tumor, abnormal growth _____	<input type="checkbox"/>	<input type="checkbox"/>
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus) _____	<input type="checkbox"/>	<input type="checkbox"/>	41. radiation therapy _____	<input type="checkbox"/>	<input type="checkbox"/>
17. kidney disease _____	<input type="checkbox"/>	<input type="checkbox"/>	42. chemotherapy, immunosuppressive medication _____	<input type="checkbox"/>	<input type="checkbox"/>
18. liver disease _____	<input type="checkbox"/>	<input type="checkbox"/>	43. emotional difficulties _____	<input type="checkbox"/>	<input type="checkbox"/>
19. jaundice _____	<input type="checkbox"/>	<input type="checkbox"/>	44. psychiatric treatment _____	<input type="checkbox"/>	<input type="checkbox"/>
20. thyroid, parathyroid disease, or calcium deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>	45. antidepressant medication _____	<input type="checkbox"/>	<input type="checkbox"/>
21. hormone deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>	46. alcohol/recreational drug use _____	<input type="checkbox"/>	<input type="checkbox"/>
22. high cholesterol or taking statin drugs _____	<input type="checkbox"/>	<input type="checkbox"/>	<b>ARE YOU:</b>		
23. diabetes (HbA1c = _____)	<input type="checkbox"/>	<input type="checkbox"/>	47. presently being treated for any other illness _____	<input type="checkbox"/>	<input type="checkbox"/>
24. stomach or duodenal ulcer _____	<input type="checkbox"/>	<input type="checkbox"/>	48. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) _____	<input type="checkbox"/>	<input type="checkbox"/>
25. digestive or eating disorders (e.g., celiac disease, gastric reflux, bulimia, anorexia) _____	<input type="checkbox"/>	<input type="checkbox"/>	49. taking medication for weight management _____	<input type="checkbox"/>	<input type="checkbox"/>
			50. taking dietary supplements _____	<input type="checkbox"/>	<input type="checkbox"/>
			51. often exhausted or fatigued _____	<input type="checkbox"/>	<input type="checkbox"/>
			52. experiencing frequent headaches _____	<input type="checkbox"/>	<input type="checkbox"/>
			53. a smoker, smoked previously or use smokeless tobacco _____	<input type="checkbox"/>	<input type="checkbox"/>
			54. considered a touchy/sensitive person _____	<input type="checkbox"/>	<input type="checkbox"/>
			55. often unhappy or depressed _____	<input type="checkbox"/>	<input type="checkbox"/>
			56. taking birth control pills _____	<input type="checkbox"/>	<input type="checkbox"/>
			57. currently pregnant _____	<input type="checkbox"/>	<input type="checkbox"/>
			58. diagnosed with a prostate disorder _____	<input type="checkbox"/>	<input type="checkbox"/>

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

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

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

# DENTAL HISTORY

Name \_\_\_\_\_ Nickname \_\_\_\_\_ Age \_\_\_\_\_  
Referred by \_\_\_\_\_ 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 \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of most recent x-rays \_\_\_\_/\_\_\_\_/\_\_\_\_  
Date of most recent treatment (other than a cleaning) \_\_\_\_/\_\_\_\_/\_\_\_\_  
I routinely see my dentist every:  3 mo.  4 mo.  6 mo.  12 mo.  Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? \_\_\_\_\_

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

YES NO

## PERSONAL HISTORY



- Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [\_\_\_\_] \_\_\_\_\_
- Have you had an unfavorable dental experience? \_\_\_\_\_
- Have you ever had complications from past dental treatment? \_\_\_\_\_
- Have you ever had trouble getting numb or had any reactions to local anesthetic? \_\_\_\_\_
- Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? \_\_\_\_\_
- Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma? \_\_\_\_\_

## GUM AND BONE



- Do your gums bleed or are they painful when brushing or flossing? \_\_\_\_\_
- Have you ever been treated for gum disease or been told you have lost bone around your teeth? \_\_\_\_\_
- Have you ever noticed an unpleasant taste or odor in your mouth? \_\_\_\_\_
- Is there anyone with a history of periodontal disease in your family? \_\_\_\_\_
- Have you ever experienced gum recession? \_\_\_\_\_
- Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? \_\_\_\_\_
- Have you experienced a burning or painful sensation in your mouth not related to your teeth? \_\_\_\_\_

## TOOTH STRUCTURE



- Have you had any cavities within the past 3 years? \_\_\_\_\_
- Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? \_\_\_\_\_
- Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? \_\_\_\_\_
- Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? \_\_\_\_\_
- Do you have grooves or notches on your teeth near the gum line? \_\_\_\_\_
- Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? \_\_\_\_\_
- Do you frequently get food caught between any teeth? \_\_\_\_\_

## BITE AND JAW JOINT



- Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) \_\_\_\_\_
- Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together? \_\_\_\_\_
- Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? \_\_\_\_\_
- In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? \_\_\_\_\_
- Are your teeth becoming more crooked, crowded, or overlapped? \_\_\_\_\_
- Are your teeth developing spaces or becoming more loose? \_\_\_\_\_
- Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together? \_\_\_\_\_
- Do you place your tongue between your teeth or close your teeth against your tongue? \_\_\_\_\_
- Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? \_\_\_\_\_
- Do you clench or grind your teeth together in the daytime or make them sore? \_\_\_\_\_
- Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth? \_\_\_\_\_
- Do you wear or have you ever worn a bite appliance? \_\_\_\_\_

## SMILE CHARACTERISTICS



- Is there anything about the appearance of your teeth that you would like to change (shape, color, size)? \_\_\_\_\_
- Have you ever whitened (bleached) your teeth? \_\_\_\_\_
- Have you felt uncomfortable or self-conscious about the appearance of your teeth? \_\_\_\_\_
- Have you been disappointed with the appearance of previous dental work? \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_