



FAMILY DENTISTRY, P.C.
Victor H. Burdick, Jr., DDS

GENERAL INFORMATION

PATIENT NAME Last First Nickname

DATE OF BIRTH MALE FEMALE Married Single Widowed

HOW DID YOU HEAR ABOUT OUR PRACTICE?

ADDRESS CITY STATE ZIP

PHONE Home Work Cell

EMAIL

SOCIAL SECURITY NUMBER (for insurance purposes)

Emergency Contact 1 Name Relationship to you Phone

Emergency Contact 2 Name Relationship to you Phone

INSURED OR RESPONSIBLE PARTY INFORMATION:

NAME Is insured an existing patient? Yes No Relationship to patient

ADDRESS

PHONE Home Work Cell

DATE OF BIRTH SOCIAL SECURITY NUMBER (for insurance purposes)

INSURED'S EMPLOYER NAME EMPLOYER PHONE

EMPLOYER ADDRESS

INSURANCE PLAN NAME ID# GROUP#

ADDRESS PHONE

MEDICAL HISTORY

DO YOU HAVE OR HAVE YOU EVER HAD:

- Allergic reaction to: aspirin, ibuprofen, or acetaminophen; penicillin; erythromycin; tetracycline; codeine; local anesthetic; fluoride; metals; latex; other
Anemia; Arthritis; Artificial Joints; Artificial Heart Valve; Asthma; Blood Disease; Blood Pressure: High Low; Cancer; Radiation; Chemotherapy; Cyst or abnormal growth; Diabetes; Sleep Apnea; Snoring
Digestive Disorders; Dizziness; Epilepsy / Seizures; Fainting; Glaucoma; Head Injury; Heart Disease; Hepatitis; HIV / AIDS; Hives or skin rash; Jaundice; Kidney Disease
Liver Disease; Mental or Nervous Disorders; Osteoporosis, Osteopenia, Pagets Disease; Medications; Pacemaker; Respiratory: COPD Emphysema; Sinus Problems; STD; Stomach Problems / Acid Reflex; Stroke; Thyroid or Parathyroid Disease; Tuberculosis

HOW WOULD YOU DESCRIBE YOUR PRESENT HEALTH? Excellent Good Fair Poor

FEMALES: ARE YOU PREGNANT OR MIGHT YOU BE? YES Due Date NO

DO YOU USE TOBACCO? YES What type? How much or how often? NO

LIST ANY MEDICATIONS, HERBAL SUPPLEMENTS, AND/OR VITAMINS YOU ARE TAKING

PLEASE DESCRIBE ANY CURRENT MEDICAL TREATMENT, IMPENDING SURGERY, OR OTHER HEALTH ISSUES YOU CURRENTLY HAVE

# Dental History

Referred By \_\_\_\_\_ How Would You Rate The Condition of Your Mouth?  Excellent  Good  Fair  Poor

Previous Dentist \_\_\_\_\_ How Long Were You A Patient? \_\_\_\_\_ months / years

Most Recent Dental Exam \_\_\_/\_\_\_/\_\_\_ Most Recent X-Rays \_\_\_/\_\_\_/\_\_\_ Most Recent Dental Treatment (other than a cleaning) \_\_\_/\_\_\_/\_\_\_

How Often Do You Routinely See Your Dentist?  Every 3 Months  Every 4 Months  Every 6 Months  Every 12 Months  Not Routinely

What Is Your Immediate Concern? \_\_\_\_\_

Please Answer Yes or No To Each of The Following Questions:

**Personal History**

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 1. Are you fearful of dental treatment? If yes, rate on a scale of 1-10 (ten being very fearful): _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you had an unfavorable dental experience? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had complications from past dental treatment?.....                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever had trouble getting numb or reactions to local anesthetic? .....                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Did you ever have braces, orthodontic treatment or your bite adjusted? .....                         | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any teeth removed?.....   | <input type="checkbox"/> | <input type="checkbox"/> |

**Smile Characteristics**

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 7. Is there anything about the appearance of your teeth that you would like to change? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever whitened (bleached) your teeth?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Are you self-conscious about your teeth?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you been disappointed with the appearance of previous dental work? .....            | <input type="checkbox"/> | <input type="checkbox"/> |

**Bite & Jaw Joint**

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 11. Do you have any problems chewing gum?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you have any problems chewing bagels or other hard foods? .....                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have your teeth changed in the last five years, become shorter, thinner, or worn .....            | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Are your teeth crowding or developing spaces?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Do you have more than one bite, or do you clench (squeeze) to make your teeth fit together? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Do you have any problems with sleep in general, or wake up with an awareness of your teeth? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Do you have problems with your jaw joint (pain, sounds, limited opening, locking, popping)? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Do you have tension headaches or sore teeth? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Do you wear, or have you ever worn a bite appliance?.....   | <input type="checkbox"/> | <input type="checkbox"/> |

**Tooth Structure**

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 20. Have you had any cavities in the past 3 years? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Do you have a dry mouth? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Are any teeth sensitive to hot, cold, biting, or sweets?.....                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Have you ever had a toothache, cracked filling, or a broken, chipped or cracked tooth? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Do you avoid brushing any part of your mouth?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Do you feel or notice any holes (pitting) in your teeth? .....                               | <input type="checkbox"/> | <input type="checkbox"/> |

**Gum & Bone**

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 26. Have you ever been diagnosed or treated for periodontal (gum) disease? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Have you ever experienced gum recession? .....                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Is there anyone with a history of periodontal disease in your family? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Do your gums bleed when brushing, flossing or eating?.....                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Are your teeth becoming loose?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Have you ever noticed an unpleasant taste or odor in your mouth? .....       | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Have you experienced a burning sensation in your mouth?.....                 | <input type="checkbox"/> | <input type="checkbox"/> |

I consent to dental and oral surgical procedures deemed necessary or advisable, including the use of local anesthetic. To the the best of my knowledge, all information I have provided is correct.

I also acknowledge full responsibility for the payment of such services and agree to pay for them, in full, at the time of service, unless other arrangements are made in advance. I also understand that a 48 hour notice is required for cancellations, otherwise a charge may be incurred.

Patient Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_ Doctor Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_